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CLAIMS FILING

Hard copy billing of DME services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required (but only in certain circumstances as detailed in the instructions that follow).

Paper claims should be submitted to:

Molina Medicaid Solutions P.O. Box 91020 Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at <u>www.lamedicaid.com</u>, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.

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This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

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CMS 1500 (02/12) INSTRUCTIONS FOR DME SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "DME" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the	
	Sex	recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	Optional.	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

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9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	Only the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC	Leave Blank.	
9с	RESERVED FOR NUCC	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	

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15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Leave Blank.	
17a	Unlabeled	Leave Blank.	
17b	NPI	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		
20	Outside Lab?	Optional.	
	ICD Ind.	Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 9 ICD-9-CM 0 ICD-10-CM	The most specific diagnosis codes must be used. General codes are not acceptable.
21	Diagnosis or Nature of Illness or Injury	Required – Enter the most current ICD diagnosis code. NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD- 10-CM codes will be announced at a later date.

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22	Resubmission Code	 Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: 	Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).
		Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider	To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.
23	Prior Authorization Number	00 = Other Required – Enter the correct 9-Digit PA number in this field.	
24	Supplemental Information	Situational - DME Providers are required to enter 11- digit NDC codes on claim detail lines for enteral feeding products only. In addition to the procedure code, the National Drug Code (NDC) is required by the Deficit Reduction Act of 2005 and <u>shall be entered</u> in the <u>shaded</u> section of 24A through 24g. Claims for enteral feeding products must include the NDC from the label of the product administered. A list of the procedure codes and NDCs for products that currently require NDC information can be found on <u>www.lamedicaid.com</u> under the Fee Schedules directory link.	DME providers must enter NDC information in the SHADED section of 24A through 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s). The NDC indicated on the claim must match the NDC on the Prior Authorization.

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			Required Enter the date of service for each procedure.	
	24A	Date(s) of Service	Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
	24B	Place of Service	Required Enter the appropriate place of service code for the services rendered.	
	24C	EMG	Situational – Complete is appropriate or leave blank.	
			Required Enter the procedure code(s) for services rendered in the un-shaded area(s).	
	24D	Procedures, Services, or Supplies	When a modifier(s) is required, enter the applicable modifier in the appropriate field.	Where modifiers are required, the modifier(s) on the claim must match the modifier(s) on the Prior Authorization
	24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block. More than one diagnosis/reference number may be related	
			to a single procedure code.	
	24F	\$Charges	Required Enter usual and customary charges for the service rendered.	
	24G	Days or Units	Required Enter the number of units billed for the procedure code entered on the same line in 24D	
	24H	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
	241	I.D. Qual.	Optional . If possible, leave blank for Louisiana Medicaid billing.	2
	24J	Rendering Provider I.D. #	Leave Blank.	
	25	Federal Tax I.D. Number	Optional.	
	26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	

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		Optional. Claim filing acknowledges acceptance of	
27	Accept Assignment?	Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	 Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. Do not report Medicare payments in this field. 	
30	RESERVED FOR NUCC USE	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional . The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	Required Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	 Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier – Optional – If possible, do not enter a qualifier for Louisiana Medicaid claims. 	The 7-digit Medicaid Provider Number must appear on paper claims.

REMINDER: MAKE SURE "DME" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

A sample form is on the following page

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SAMPLE DME CLAIM FORM

HEALTH INSURAN APPROVED BY NATIONAL UNI				00/40										
	FORM CLAIN	COMMI	TEE (NOCC)	02/12										PICA
1. MEDICARE MEDICAI	D TR	ICARE	СН	IAMP VA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S	LD. NU	MBER		(For Progra	am in Item 1)
(Medicare #) 🗙 (Medicaid	(ID	#/DoD#)	(Me	ember ID#)	(ID#)	(ID#)	(ID#)	12345678	90123					
2. PATIENT'S NAME (Last Nan	ne, First Nam	e, Middle	Initial)	3. P/	ATIENT'S BIRTH D	ATE S Y	EX	4. INSURED'S	NAME (L	ast Nam	e, First Na	ame, Mide	dle Initial)	
Adalam, Mary					06 11 0		FΧ							
5. PATIENT'S ADDRESS (No.,	Street)				ATIENT RELATION			7. INSURED'S	ADDRES	S (No., S	Street)			
CITY				TATE 8.RF	elf Spouse SERVED FOR NU		Other	СПУ						STATE
CITY			5	TATE 8. RE	SERVED FOR NU	ICC USE		CIT						STATE
ZIP CODE	TELEPHO	NE (Inclu	de Area Code))				ZIP CODE			TELEPH	IONE (In	dude Area	a Code)
	()									()		
9. OTHER INSURED'S NAME	Last Name, F	/	e, Middle Initial	l) 10. l	IS PATIENT'S COM	NDITION RELA	TED TO:	11. INSURED'S	POLICY	GROUF	OR FEC	- C	ER	
a. OTHER INSURED'S POLICY	OR GROUP	NUMBER	R	a. EM	MPLOYMENT? (Cu	rrent or Previo	13)	a. INSURED	SDATE		н		SEX	
TPL Code if applicab					YES	NO			~			м		F
b. RESERVED FOR NUCC US	E			b. Al	JTO ACCIDENT?	P	LACE (State)	b. OTHER CLA	IM ID (De	esignated	i by NUC	C)		
					YES									
c. RESERVED FOR NUCC US	E			c. 01	THER ACCIDENT?			c. INSURANCE	PLAN N	AME OR	PROGR	AM NAME	E	
					YES	NO								
d. INSURANCE PLAN NAME C	RPROGRAM	NAME		10d.	RESERVED FOR	LOCAL USE		d. IS THERE A						
						-		YES	N				ns 9, 9a a	
REAL 12. PATIENT'S OR AUTHORIZI to process this claim. I also re below.	ED PERSON	S SIGNAT	TURE lauthor	rize the releas	SNING THIS FORM se of any medical o elf or to the party wi	r other informat	ion necessary Inment	services de	medical t scribed b	penefits to	o the und	arsigned	physician	l authorize or supplier for
SIGNED				SAN	ИPLE	E FC)RI)R					
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ISSUED: 0 REPLACED: 0

02/04/15 04/30/14

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ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

<u>Only a paid claim can be adjusted or voided</u>. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

ISSUED: (REPLACED: (

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

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Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

A sample form is on the following page

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

SIGNED Ima Biller

DATE 3/9/14 a.

NUCC Instruction Manual available at: www.nucc.org

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CARRIER --->

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION

PHYSICIAN OR

1987654

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

回信日 日本 HEALTH INSURANCE CLAIM FORM HEALTH INSURANCE CLAIM FORM		DM	E							
	00,0212									PICA
1. MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUN	OTHER	1a. INSURED'S	I.D. NL	IMBER		(For Progra	am in Item 1)
(Medicare #) 🗙 (Medicaid #) (ID#/DoD#)	(Member ID)#) (ID#)	(ID#)	(ID#)	123456789	9012:	3			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Adalam, Mary		3. PATIENT'S BIRTH D/ MM DD YY 06 11 00		SEX F X	4. INSURED'S I				, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATION			7. INSURED'S /	ADDRE	SS (No.,	Street)		
СПУ	STATE	Self Spouse 8. RESERVED FOR NU(Child CC USE	Other	СПҮ					STATE
ZIP CODE TELEPHONE (Include Area C	Control)				ZIP CODE			TELEDHON	E (Include Area	Code)
Le COLLE TELEPHONE (Include Area C					LIF CODE			()	a 000e)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle I	Initial)	10. IS PATIENT'S CON	DITION REL	ATED TO:	11. INSURED'S	POLIC	Y GROU	P OR FECA N	UMBER	
	,									
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Cur	rrent or Previ	ous)	a. INSURED'	S DATE	OF BIR	тн	SEX	
TPL Code if applicable		YES	NC	>	i			м		F
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?		PLACE (State)	b. OTHER CLA	M ID (C)esignate	d by NUCC)		
		YES	NC	°	c. INSURANCE	DIAN		PPPOCRAM	NAME	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?			C. INSURANCE	PLANI	NHME OF	RPROGRAM	NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		YES 10d. RESERVED FOR L	NC OCAL USE	,	d. IS THERE AN	OTHE	R HEALT	H BENEFIT P	LAN?	
					YES				e items 9, 9a a	nd 9d.
12. PATENTS OR AUTHORIZED PERSON'S SIGNATURE 1 a b process this claim. I alios request payment of government ber below. SIGNED 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (II D D D U QUAL	s A		EF(or or other	services des	R	below.		DURRENT OCI MM	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 7 1b.				18. HOSPITALIZ MM				CURRENT SE	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		II			20. OUTSIDE L YES		NO 0	\$ CH/	ARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Rela	ate A-L to ser	rvice line below (24E)	CD Ind. 9	1	22. RESUBMIS		1	ORIGINAL I		
A. 13439 B. 1V441	C		D		23. PRIOR AUT	199			5678600	
E F	G		н.		412345678		ATION N	OMDER		
1 J 24. A. DATE(S) OF SERVICE B. C.	K. D.PROCE	DURES, SERVICES, OR	L. SUPPLIES	E.	F.	-	G. DAYS	H. L		J.
From To PLACE OF MM DD YY MM DD YY SERVICE EMG	(Expl CPT/HCP	lain Unusual Circumstanc	es)	DIAGNOSIS POINTER	\$ CHARGE	s	DAYS OR UNITS	H. I. EPSOT ID. Family Plan QUAL.	PRO	NDERING VIDER ID. #
03 02 14 03 02 14 12	B4160		1	AB	450	00	200	NPI	[
								NPI		
			1					NPI		
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. F	PATIENT'S A	CCOUNT NO. 27.	ACCEPT AS	SIGNMENT?	28. TOTAL CH			9. AMOUNT P	AID 30. B/	ALA NCE DUE
		×	YES	NO	*	450		\$	\$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. S INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	SERVICE FA	CILITY LOCATION INFO	RMATION		33. BILLING PI	ble N				4957

b.

PLEASE PRINT OR TYPE

700 Main St Any Town, LA 70000 a. 1326547895 b.

02/04/15 04/30/14

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

APPENDIX B – CLAIMS FILING

PICA			PICA
MEDICARE MEDICAID TRICARE CHAMP (Medicare#) (Medicald#) (IDM/DoD#) (Member	HEALTH PLAN - BLK LUNG -	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
ATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First N	lame, Middle Initial)
	MF		
ATIENT'S ADDRE88 (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)	
Y STATE		CITY	STATE
CODE TELEPHONE (Include Area Code)		ZIP CODE TELEF	HONE (Include Area Code)
()		(
THER INSURED'S NAME (Last Name, First Name, Mickle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FE	CANUMBER
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX
	YES NO		M F
ESERVED FOR NUCC USE	b. AUTO ACCIDENTY PLACE (State)	b. OTHER CLAIM ID (Designated by NUI	BC)
ESERVED FOR NUCC USE	G. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGR	RAM NAME
NSURANCE PLAN NAME OR PROGRAM NAME	YES. NO 10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENED	
	TOD. OLANIN CLURED (Designment by HOCC)		omplete Items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETIN PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the to process this claim. I also request payment of government banefits either	G & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERS	ON'S SIGNATURE I authoriza
to process this claim. I also request payment of government benefits eithe below.	r to myself or to the party who accepts assignment	payment of medical benefits to the un services described below.	
SIGNED	DATE	SIGNED	
	OTHER DATE NM DD YY	18. DATES PATIENT UNABLE TO WORK	KIN CURRENT OCCUPATION MM DD YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE 12		18. HOSPITALIZATION DATES RELATE	
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	b. NPI	FROM 20. OUTSIDE LAB?	TO CHARGES
ACCOLLINATE COMMINICATION (Designation by MCCC)		YES NO	e Grandes
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to see	vice line below (24E) ICD ind.	22. RESUBMISSION ORIGIN	VAL REF. NO.
в с.	D	23. PRIOR AUTHORIZATION NUMBER	
F. G.	H		
A. DATE(S) OF SERVICE B. C. D. PROC From To PLACEOF (Exp	EDURES, SERVICES, OR SUPPLIES E. aln Unusual Circumstances) DIAGINOSIS PCS MODIFIER POINTER	F. G. H. DAYS EPSOT OR Family	I. J. ID. RENDERING
L DD YY MM DD YY SERVICE EMG CPT/HC	PCS MODIFIER POINTER	\$ CHARGES UNITS Pier (QUAL PROVIDER ID. #
			NPI
			NPI
			NPI
			NPI
			NO
			NPI
			NPI
	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUN	NT PAID 30. Ravel for NUCC
FEDERAL TAX I.D. NUMBER S8N EIN 28. PATIENT'S	YES NO	\$ S	1