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CHAPTER 46: VISION (EYEWEAR) SERVICES

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## APPENDIX C: CLAIMS FILING

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**CLAIMS FILING**

Hard copy billing of vision (eyewear) services is 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 may 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:

**Gainwell Technologies  
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 [www.lamedicaid.com](http://www.lamedicaid.com), 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 samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

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## CMS 1500 (02/12) INSTRUCTIONS FOR VISION SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	<b>Required</b> -- Enter the beneficiary's 13 digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS, or REVS.  <b>NOTE:</b> The beneficiary's 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	<b>Required</b> -- Enter the beneficiary's last name, first name, middle initial.	
3	Patient's Birth Date  Sex	<b>Situational</b> -- Enter the beneficiary's date of birth using six 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 beneficiary.	
4	Insured's Name	<b>Situational</b> -- Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> -- Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> -- Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> -- Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	<b>Leave Blank.</b>	
9	Other Insured's Name	<b>Situational</b> -- Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<b>Situational</b> -- If beneficiary has no other coverage, leave blank.  If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is <b>required</b> 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.	<b>ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.</b>  <b>DO NOT enter dashes, hyphens,</b>

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Locator #	Description	Instructions	Alerts
			<b>or the word TPL in the field.</b>  <b>NOTE: DO NOT ENTER A 6 DIGIT CODE FOR TRADITIONAL MEDICARE.</b>
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	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	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	

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Locator #	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	<p>Situational – Complete if applicable.</p> <p>In the following circumstance, entering the name of the appropriate physician is required:</p> <ul style="list-style-type: none"> <li>If Services are performed at the request of an ordering provider:</li> </ul> <p>Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported.</p> <ul style="list-style-type: none"> <li>DK Ordering Provider</li> </ul> <p>Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who ordered the service(s) or supply(ies) on the claim.</p>	<p>For LA Medicaid other source is defined as the ordering provider.</p> <p>The ordering provider is required.</p> <p>Referring provider is not required.</p>
17a	Other Identification Number (ID#)	<p>Situational – Complete if applicable.</p> <p>If 17 is completed, 17A is required.</p>	Enter the 7-digit Medicaid ID Number here.
17b	NPI	<p>Situational – Complete if applicable.</p> <p>If 17 is completed, 17B is required.</p>	The 10-digit NPI Number is required when 17 or 17A is complete.
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
21	ICD Indicator  Diagnosis or Nature of Illness or Injury	<p><b>Required</b> – 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.</p> <p>0 ICD-10-CM</p> <p><b>Required</b> – Enter the most current ICD diagnosis code.</p> <p><b>NOTE:</b> ICD-10-CM “V”, “W”, “X”, &amp; “Y” series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	The most specific diagnosis codes must be used. General codes are not acceptable.

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Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	<p><b>Situational.</b> 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.</p> <p>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.</p> <p>Appropriate reason codes follow:</p> <p>Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p>VOIDS 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	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	<p><b>Situational</b> – Complete if appropriate or leave blank.</p> <p>If the services being billed must be Prior Authorized, the PA number is <b>required</b> to be entered.</p>	
24	Supplemental Information	<b>Leave Blank.</b>	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	<b>Required</b> -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	<b>Leave Blank.</b>	
24D	Procedures, Services, or Supplies	<p><b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</p> <p>When a modifier(s) is required, enter the appropriate modifier in the correct field.</p>	

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24E	Diagnosis Pointer	<p><b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
24F	Amount Charged	<b>Required</b> – Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> – Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	<b>Leave Blank.</b>	
24I	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	<p><b>Situational</b> – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b>.</p> <p>Entering the Rendering Provider’s NPI in the non-shaded portion of the block is Required if the shaded portion is complete.</p>	<p><b>Both the 7-digit Medicaid provider number and the 10-digit NPI numbers are required when entering a rendering provider.</b></p> <p><b>Rendering =Attending</b></p>
25	Federal Tax I.D. Number	<b>Optional.</b>	
26	Patient’s Account No.	<b>Situational</b> – Enter the provider specific identifier assigned to the beneficiary. 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.	
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	<p><b>Situational</b> – 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.</p> <p>If TPL does not apply to the claim, leave blank.</p>	<b>Do not report Medicare or Medicare Replacement plan payments in this field.</b>
30	RESERVED FOR NUCC USE	<b>Leave Blank.</b>	

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<b>31</b>	Signature of Physician or Supplier Including Degrees or Credentials	<b>Optional.</b> The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	<b>Required</b> -- Enter the date of the signature.	
<b>32</b>	Service Facility Location Information	<b>Situational</b> -- Complete as appropriate or leave blank.	
<b>32a</b>	NPI	<b>Optional.</b>	
<b>32b</b>	Other ID#	<b>Situational</b> -- Complete as appropriate or leave blank.	
<b>33</b>	Billing Provider Info and Phone #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	
<b>33a</b>	NPI	<b>Required</b> -- Enter the billing provider's 10-digit NPI number.	The 10-digit NPI Number must appear on paper claims.
<b>33b</b>	Other ID#	<b>Required</b> -- Enter the billing provider's 7-digit Medicaid ID number.  <b>ID Qualifier – Optional</b> -- If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

Sample forms are on the following page




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## SAMPLE VISION CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES OF SERVICE ON OR AFTER 10/01/15)



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail To:  
Gainwell Technologies  
P.O. Box 91020  
Baton Rouge, LA 70821

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRI-CARE CHAMPVA GROUP HEALTH PLAN FECA EX-CLUNG OTHER  
(Medicare#) (X) (Medicaid#) (ICMDC#) (Member ID#) (ID#) (ID#) (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
LOU, JANNIE

3. PATIENT'S BIRTH DATE  
MM DD YY 06 11 07 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)  
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED  
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)  
CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:  
a. EXISTING ILLNESS, INJURY, OR PREGNANCY? YES NO  
b. AUTO ACCIDENT? YES NO  
c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)  
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)  
SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)  
MM DD YY QUAL

15. OTHER DATE  
MM DD YY QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
DK JON DOE, MD

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (246))  
A. H5034 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER  
PA # IF APPLICABLE

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. SPOT TREATING RATE I. ID. QUAL J. RENDERING PROVIDER ID. #

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234

27. ACCEPT ASSIGNMENT? (For bill claims, see back) X YES NO

28. TOTAL CHARGE \$ 375.00

29. AMOUNT PAID \$

30. Rev'd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  
JANE DOE, MD

32. SERVICE FACILITY LOCATION INFORMATION  
a. NPI b.

33. BILLING PROVIDER INFO & PH# (800) 233-3333  
ALWAYS OPEN  
700 MAIN ST  
ANY TOWN, LA 70000  
a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0936-1197 FORM 1500 (02-12)

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**ADJUSTING/VOIDING CLAIMS**

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

Only a paid claim can be adjusted or voided. 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; and
- 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 Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

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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.

**Sample forms are on the following pages.**

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**SAMPLE VISION CLAIM FORM WITH ICD-10 DIAGNOSIS CODE (DATES OF SERVICE  
ON OR AFTER 10/01/15)**

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Mail To:  
Gainwell Technologies  
P.O. Box 91020  
Baton Rouge, LA 70821

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA/WORKERS COMP <input type="checkbox"/> OTHER <input type="checkbox"/>										2. INSURED'S I.D. NUMBER 1234567890123			
3. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE						4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S ADDRESS (No., Street)					
6. PATIENT'S ADDRESS (No., Street)						7. INSURED'S ADDRESS (No., Street)		8. RESERVED FOR NUCC USE					
9. CITY						10. STATE		11. CITY					
12. ZIP CODE						13. TELEPHONE (Include Area Code)		14. ZIP CODE					
15. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						16. IS PATIENT'S CONDITION RELATED TO:		17. INSURED'S POLICY GROUP OR FECA NUMBER					
18. OTHER INSURED'S POLICY OR GROUP NUMBER TPL CODE IF APPLICABLE						19. a. EMERGENCY? (Yes/No) <input type="checkbox"/> YES <input type="checkbox"/> NO		20. a. INSURED'S DATE OF BIRTH MM DD YY M SEX F					
21. b. RESERVED FOR NUCC USE						22. b. AUTO ACCIDENT? (Yes/No) <input type="checkbox"/> YES <input type="checkbox"/> NO		23. b. OTHER CLAIM ID (Designated by NUCC)					
24. c. RESERVED FOR NUCC USE						25. c. OTHER ACCIDENT? (Yes/No) <input type="checkbox"/> YES <input type="checkbox"/> NO		26. c. INSURANCE PLAN NAME OR PROGRAM NAME					
27. d. INSURANCE PLAN NAME OR PROGRAM NAME						28. d. OTHER INSURED'S POLICY OR GROUP NUMBER		29. d. OTHER INSURED'S POLICY OR GROUP NUMBER					
30. READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												31. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
32. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (CMP) MM DD YY QUAL						33. OTHER DATE QUAL MM DD YY							
34. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK   JON DOE, MD						35. 17a. 1236548 17b. NPI 1236549875							
36. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												37. 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
38. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (24E) A. H5034 B. C. D. E. F. G. H. I. J. K. L.												39. 22. RESUBMISSION CODE A 00 ORIGINAL REF. NO. 8142178901200	
40. 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS/FINDER F. G. H. I. J. K. L.												41. 23. PRIOR AUTHORIZATION NUMBER PA # IF APPLICABLE	
42. 25. FEDERAL TAX I.D. NUMBER SIGN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For group plans, see last) 28. TOTAL CHARGE 29. AMOUNT PAID 30. Res'd for NUCC Use												43. 31. BILLING PROVIDER INFO & PH# (800) 233-3333	
44. 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (800) 233-3333												45. 34. BILLING PROVIDER INFO & PH# (800) 233-3333	
46. 35. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including discharges or credentials & certify that the statements on this reverse apply to this bill and are made a part thereof.) JANE DOE, MD 06/05/2018												47. 36. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including discharges or credentials & certify that the statements on this reverse apply to this bill and are made a part thereof.) JANE DOE, MD 06/05/2018	
48. 37. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including discharges or credentials & certify that the statements on this reverse apply to this bill and are made a part thereof.) JANE DOE, MD 06/05/2018												49. 38. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including discharges or credentials & certify that the statements on this reverse apply to this bill and are made a part thereof.) JANE DOE, MD 06/05/2018	

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## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA/BULKING <input type="checkbox"/> OTHER										<input type="checkbox"/> PCA <input type="checkbox"/> PCA									
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ICM/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA/BULKING (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										14. INSURED'S ID NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No. Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY										7. INSURED'S ADDRESS (No. Street)									
STATE										8. RESERVED FOR NUCC USE									
ZIP CODE										CITY									
TELEPHONE (Include Area Code)										STATE									
3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
4. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
5. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____									
6. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
6. INSURANCE PLAN NAME OR PROGRAM NAME										10a. CLAIM CODES (Designated by NUCC)									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED _____ DATE _____										12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate to service line below (24E) ICD-10 _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-10 Code I. ICD-10 Qual. J. RENDERING PROVIDER ID, #										23. PRIOR AUTHORIZATION NUMBER									
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX ID NUMBER SSN/EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$									
29. AMOUNT PAID \$										30. Rev'd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # ( )										34. BILLING PROVIDER INFO & PH # ( )									
SIGNED _____ DATE _____										SIGNED _____ DATE _____									

NUCC Instruction Manual available at: www.nucc.org

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