LOUISIANA DEPARTMENT OF HEALTH

FREE-STANDING BIRTHING CENTERS

Chapter Twenty-Eight of the Medicaid Services Manual

Issued April 20, 2016

State of Louisiana
Bureau of Health Services Financing

FREE-STANDING BIRTHING CENTERS

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OVERVIEW

Free-standing birthing centers (FSBCs) provide delivery services to eligible Medicaid beneficiaries not requiring hospitalization and which the expected duration of services would not exceed 24 hours following an admission. A FSBC is a free-standing facility, separate from a hospital, which meets the needs of eligible beneficiaries. Eligible beneficiaries who have had a low risk pregnancy, meaning a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

The purpose of this chapter is to set forth the conditions and requirements an FSBC must meet in order to qualify for reimbursement under the Louisiana Medicaid program. The manual is intended to make available to Medicaid providers of delivery services within FSBCs a ready reference for information and procedural material needed for the prompt and accurate filing of claims for services furnished to Medicaid beneficiaries.

COVERED SERVICES

A free-standing birthing center (FSBC) is any distinct entity that operates exclusively for the purpose of providing vaginal delivery services to those beneficiaries not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.

The services must be medically necessary and furnished to an eligible pregnant woman by, or under, the direction of an obstetrician, family practitioner, certified nurse midwife or licensed midwife in a facility which is not part of a hospital, but which is organized and operated to provide delivery care to beneficiaries.

FSBCs are reimbursed a flat fee for labor and low-risk delivery services that include all charges by the facility for the care of the beneficiary while the beneficiary is in the center.

Services are provided by the attending practitioner from the time of the pregnant woman's admission through the birth and the immediate postpartum period.

Non-Covered Services

1. Neither general nor epidural anesthesia shall be provided in the birthing center; and

2. Assessments for active labor that do not result in admission to the birthing center.

Exclusions

FSBC services do not include items and services for which payment may be made under other provisions. FSBC services do not include:

1. Physician services;

2. Laboratory and x-ray not directly related to the delivery;

3. Diagnostic procedures (other than those directly related to performance of the delivery);

4. Ambulance services; or

5. Durable medical equipment (DME) for use in the beneficiary's home.

PROVIDER REQUIREMENTS

Free-standing birthing centers (FSBCs) are required to meet specific criteria for Medicaid enrollment and must complete the enrollment process prior to providing services to Medicaid beneficiaries.

Medicaid FSBCs must meet the following enrollment criteria:

1. Be accredited by the Commission for the Accreditation of Birth Centers (CABC);

2. Be approved by the Medicaid Medical Director; and

3. Be located within a ground travel time distance from the general acute care hospital with which the center maintains a contractual relationship, including a transfer agreement, that allows for an emergency cesarean delivery to be started within 30 minutes of the decision a cesarean delivery is necessary.

Staffing Requirements

FSBCs must have a licensed obstetrician, family practitioner, certified nurse midwife or licensed midwife who shall attend each woman in labor from the time of admission through birth and the immediate postpartum period.

A licensed midwife providing birthing services within the FSBC must:

1. Have passed the national certification exam through the North American Registry of Midwives; and

2. Hold a current, unrestricted state license with the Louisiana State Board of Medical Examiners.

Physicians, certified nurse midwives, and licensed midwives* enrolled in Louisiana Medicaid are eligible to provide delivery services within Medicaid enrolled FSBCs.

*Licensed midwives providing delivery services in FSBCs must comply with the *Louisiana Administrative Code*, Title 46 Professional and Occupational Standards Part XLV. Medical Professions; Subpart 3. Practice; Chapter 53. Licensed Midwives.

REIMBURSEMENT

Reimbursement for delivery services performed in a free-standing birthing center (FSBC) is a flat fee. Each FSBC has a reimbursement rate established at the time of enrollment specific to the facility.

The flat fee reimbursement is for facility charges only, which covers all operative functions associated with the performance of a vaginal delivery including but not limited to the following:

1. Admission;
2. Patient history and physical;
3. Laboratory tests;
4. Nursing care of the laboring/delivering beneficiary and her newborn infant; and
5. All supplies related to the care and discharge of the beneficiary.

The flat fee excludes payments for the physician, certified nurse midwife or licensed midwife performing the delivery.

Billing

FSBC claims should be completed on the CMS-1500 or 837P. There should only be one line item per claim form using the current procedure code for a vaginal delivery only (this is currently Current Procedural Terminology (CPT) code 59409).

Should the beneficiary be transferred to an acute care setting for the delivery event, the center may append the modifier 53 to the procedure code for the delivery as indicated above. Reimbursement for services provided that did not result in a vaginal delivery at the FSBC will be at a reduced rate.

CONTACT INFORMATION

ASSISTANCE NEEDED	HOW TO OBTAIN
Billing Questions/Assistance	Gainwell Technologies Provider Relations P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040

CLAIMS FILING

Hard copy claims for free-standing birthing center (FSBC) services are submitted on the most current CMS-1500 claim form or electronically on the 837P transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when submitting 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.

Hardcopy claims are to be submitted to:

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

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Claims and Billing, sub-link "Health Insurance Portability and Accountability Act (HIPAA)" – "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and a sample of completed CMS-1500 claim form; and

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

CMS-1500 (12/12) INSTRUCTIONS FOR FREE-STANDING BIRTHING CENTERS

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca / Black Lung / Other	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's Identification (ID) Number	**Required** – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibility Verification System (MEVS), eMEVS, or Recipient Eligibility Verification System (REVS). **NOTE:** The beneficiary's 13-digit Medicaid ID number must be used to submit claims. The card control number (CCN) from the plastic ID card is **NOT** acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	**Required** – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB) Sex	**Situational** – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	**Situational** – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	RESERVED FOR National Uniform Claim Committee (NUCC) USE		
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If beneficiary has no other coverage, leave blank. If there is other commercial insurance coverage, the Louisiana assigned 6-digit third-party liability (TPL) carrier code is **required** in this block. The carrier code is indicated on the MEVS response as the Network Provider Identification Number. Make sure the explanation of benefits (EOB) or EOBs from other insurance(s) are attached to the claim.	**ONLY the 6-digit code should be entered for commercial and Medicare health maintenance organizations (HMOs) in this field.** **DO NOT enter dashes, hyphens or the word TPL in the field.** **NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE**
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.	

Locator #	Description	Instructions	Alerts
11	Insured's Policy, Group, or Federal Employees' Compensation Act (FECA) Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's DOB 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.**	
17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable.	
17a	Other ID #	**Optional.**	
17b	National Provider Identifier (NPI) #	**Optional.**	

Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab? $Charges	**Optional.**	
21	International Classification of Diseases (ICD) Indicator Diagnosis or Nature of Illness or Injury	**Required** -- Enter the ICD indicator to identify the current ICD coding that is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM **Required** -- Enter the most current ICD diagnosis code.	**The most specific diagnosis codes must be used. General codes are not acceptable** **ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.**

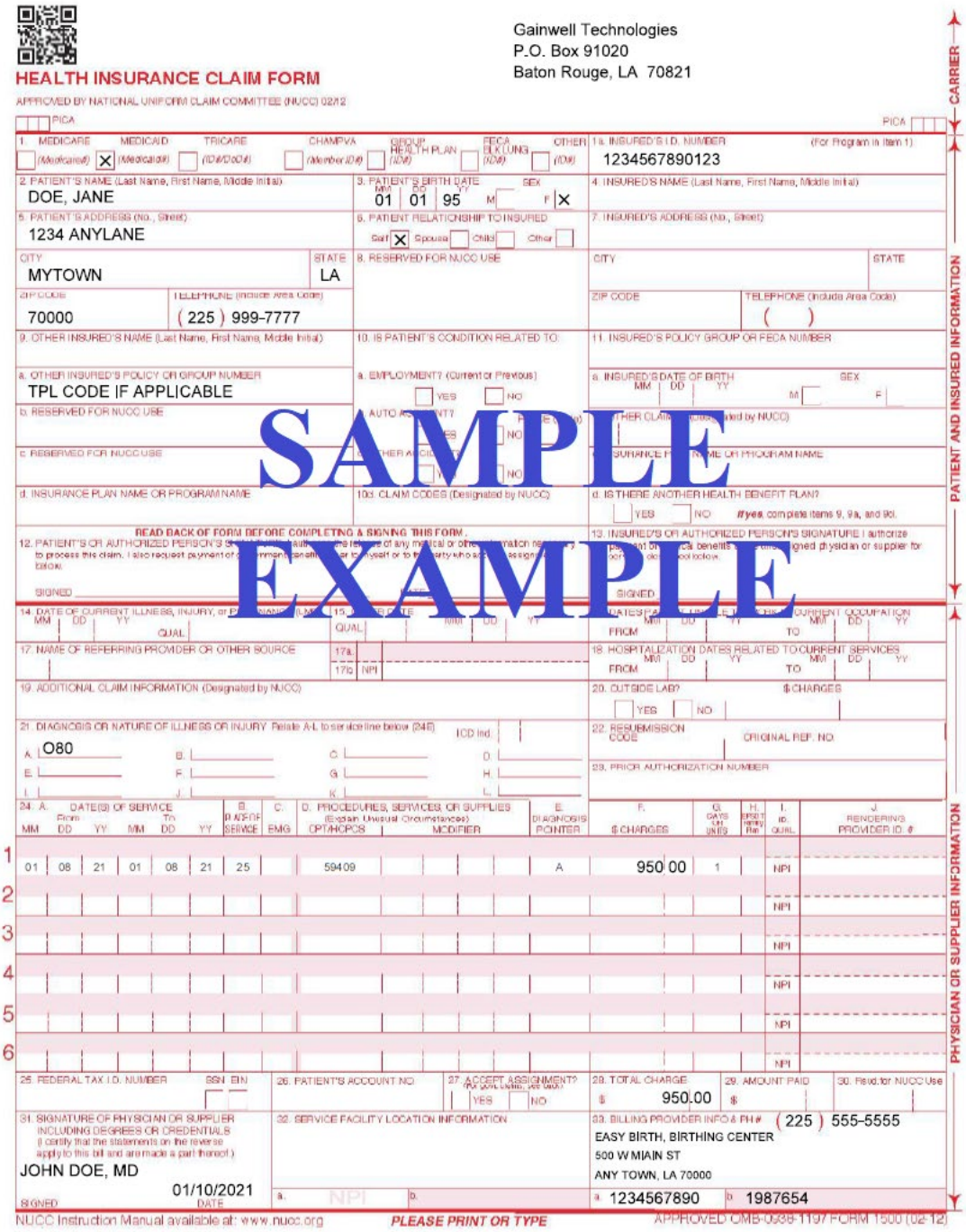
Locator #	Description	Instructions	Alerts
22	Resubmission and/or Original Reference Number	**Situational** – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Resubmission Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice (RA) in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	**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 (PA) Number	**Leave Blank**.	
24	Supplemental Information	**Leave Blank.**	
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered. **Code** / **Description** 25 / Birth Center	
24C	Electromyography (EMG)	**Situational** – Complete if appropriate or leave blank.	

<table>
<tr><th>Locator #</th><th>Description</th><th>Instructions</th><th>Alerts</th></tr>
<tr><td>24D</td><td>Procedures, Services, or Supplies</td><td>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).
<table><tr><th>Procedure</th><th>Description</th></tr><tr><td>59409</td><td>Vaginal Delivery only</td></tr></table>
If a modifier(s) is required, enter the appropriate modifier in the correct field.
<table><tr><th>Modifier</th><th>Description</th></tr><tr><td>53</td><td>Discontinued Procedure</td></tr></table></td><td></td></tr>
<tr><td>24E</td><td>Diagnosis Pointer</td><td>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number (“A”, “B”, etc.) in this block.

More than one diagnosis/reference number may be related to a single procedure code.</td><td></td></tr>
<tr><td>24F</td><td>$Charges</td><td>Required -- Enter usual and customary charges for the service rendered.</td><td></td></tr>
<tr><td>24G</td><td>Days or Units</td><td>Required -- Enter the number of units billed for the procedure code entered on the same line in 24D</td><td></td></tr>
<tr><td>24H</td><td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Family Plan</td><td>Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.</td><td></td></tr>
<tr><td>24I</td><td>ID Qualifier</td><td>Optional. If possible, leave blank for Louisiana Medicaid.</td><td></td></tr>
<tr><td>24J</td><td>Rendering Provider ID #</td><td>Leave Blank</td><td></td></tr>
<tr><td>25</td><td>Federal Tax ID Number</td><td>Optional.</td><td></td></tr>
<tr><td>26</td><td>Patient’s Account No.</td><td>Situational – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the RA. It may consist of letters and/or numbers and may be a maximum of 20 characters.</td><td></td></tr>
<tr><td>27</td><td>Accept Assignment?</td><td>Optional. Claim filing acknowledges acceptance of Medicaid assignment.</td><td></td></tr>
<tr><td>28</td><td>Total Charge</td><td>Required – Enter the total of all charges listed on the claim.</td><td></td></tr>
</table>

Locator #	Description	Instructions	Alerts
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (excluding any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional** – The practitioner or the practitioner's authorized representative's original signature is no longer required. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Optional.**	
32a	NPI#	**Optional.**	
32b	Other ID#	**Optional.**	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI#	**Required**—Enter the billing provider's 10-digit NPI number.	
33b	Other ID#	**Required** – Enter the billing provider's 7-digit Medicaid ID number. **ID Qualifier - Optional.** If possible, leave blank for Louisiana Medicaid billing.	**The 7-digit Medicaid Provider Number must appear on paper claims.**

Example Claims for Free-Standing Birthing Centers



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

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE: 01 01 95 SEX: M F X

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

5. PATIENT'S ADDRESS (No., Street): 1234 ANYLANE

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: MYTOWN STATE: LA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & 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

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 QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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 (24E) ICD Ind.

A. O80 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	08	21	01	08	21	25		59409			A	950 00	1		NPI	
2																NPI	
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 950.00

29. AMOUNT PAID $

30. Rsvd.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.)

JOHN DOE, MD

SIGNED 01/10/2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (225) 555-5555

EASY BIRTH, BIRTHING CENTER
500 W MIAIN ST
ANY TOWN, LA 70000

a. 1234567890 b. 1987654

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

EXAMPLE

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the most current CMS-1500 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 submitted 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 RA, a corrected claim may be resubmitted (if applicable).

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

1. 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

2. 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.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the RV 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.

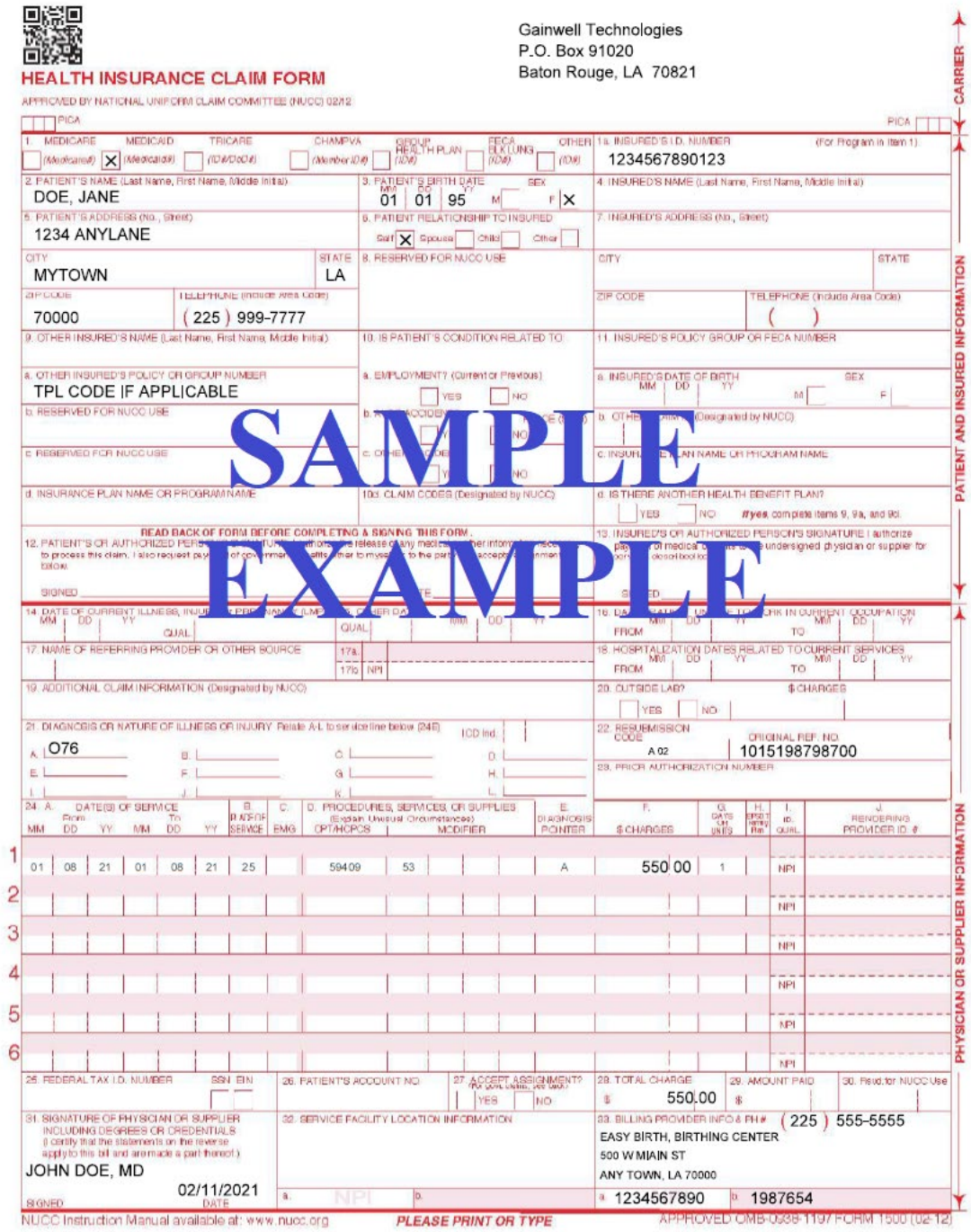
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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 RA.

Sample forms are on the following pages.

SAMPLE FREE-STANDING BIRTHING CENTER CLAIM FORM ADJUSTMENT



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

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — 1a. INSURED'S I.D. NUMBER: 1234567890123
2. PATIENT'S NAME: DOE, JANE
3. PATIENT'S BIRTH DATE: 01 01 95 — SEX: F
4. INSURED'S NAME
5. PATIENT'S ADDRESS: 1234 ANYLANE
6. PATIENT RELATIONSHIP TO INSURED: Self
7. INSURED'S ADDRESS
CITY: MYTOWN — STATE: LA
8. RESERVED FOR NUCC USE
ZIP CODE: 70000 — TELEPHONE: (225) 999-7777
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE
a. EMPLOYMENT? (Current or Previous)
a. INSURED'S DATE OF BIRTH — SEX
b. RESERVED FOR NUCC USE
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

SAMPLE

EXAMPLE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)
15. OTHER DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)
ICD Ind.
A. O76
22. RESUBMISSION CODE: A 02 — ORIGINAL REF. NO.: 1015198798700
23. PRIOR AUTHORIZATION NUMBER

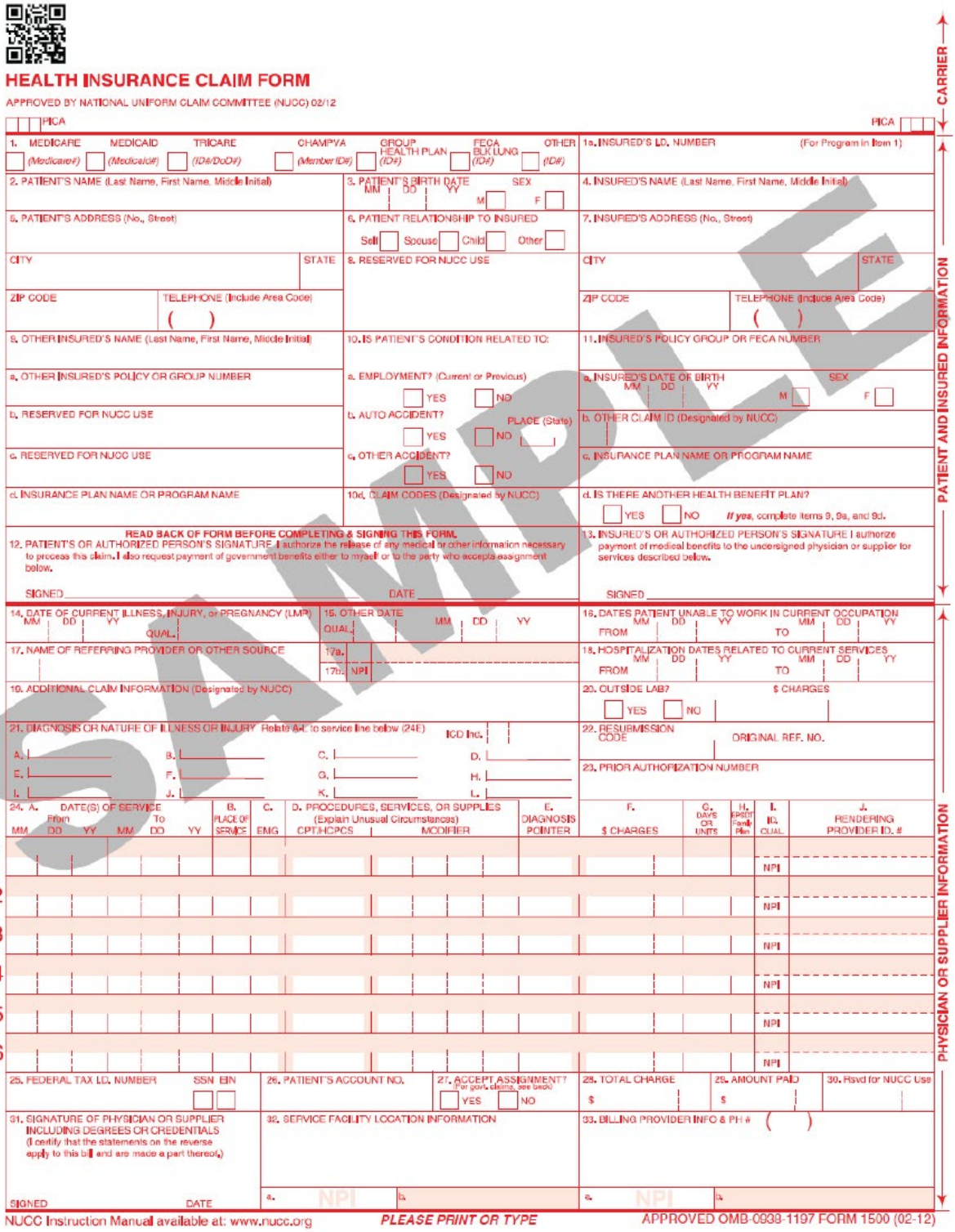
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	08	21	01	08	21	25		59409	53	A	550 00	1		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER — SSN / EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? YES / NO
28. TOTAL CHARGE: $ 550.00
29. AMOUNT PAID: $
30. Rsvd. 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.)
JOHN DOE, MD
SIGNED: 02/11/2021 DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # (225) 555-5555
EASY BIRTH, BIRTHING CENTER
500 W MIAIN ST
ANY TOWN, LA 70000
a. 1234567890 b. 1987654

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. 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 F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & 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

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 QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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 (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE