
CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

CLAIMS FILING

Hard copy billing of free-standing birthing center services are billed on the CMS-1500 (02/12) 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 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:

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

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, directory link “Claims and Billing, sub-link “HIPAA Information Center” – “5010v of the Electronic Transactions” – 837P Professional Guide.)

This appendix includes the following:

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

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

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 ID Number	Required -- Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid I.D. number must be used to bill claims. The CCN number from the plastic I.D. card is NOT acceptable. The I.D. 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 Sex	Situational -- Enter the recipient'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 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.	

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

Locator #	Description	Instructions	Alerts
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the Louisiana 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.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	<p>ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field.</p> <p>DO NOT enter dashes, hyphens or the word TPL in the field.</p> <p>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE</p>
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.	

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

Locator #	Description	Instructions	Alerts
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	NPI #	Optional.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Optional.	

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>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.</p> <p>0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable</p> <p>ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15.</p>
22	Resubmission and/or Original Reference Number	<p>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.</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><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<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.</p>
23	Prior Authorization (PA) Number	Leave Blank.	
24	Supplemental Information	Leave Blank.	
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>	

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

Locator #	Description	Instructions	Alerts								
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered. <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>25</td> <td>Birth Center</td> </tr> </tbody> </table>	Code	Description	25	Birth Center					
Code	Description										
25	Birth Center										
24C	EMG	Situational – Complete if appropriate or leave blank.									
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). <table border="1"> <thead> <tr> <th>Procedure</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>59409</td> <td>Vaginal Delivery only</td> </tr> </tbody> </table> <p>If a modifier(s) is required, enter the appropriate modifier in the correct field.</p> <table border="1"> <thead> <tr> <th>Modifier</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>53</td> <td>Discontinued Procedure</td> </tr> </tbody> </table>	Procedure	Description	59409	Vaginal Delivery only	Modifier	Description	53	Discontinued Procedure	
Procedure	Description										
59409	Vaginal Delivery only										
Modifier	Description										
53	Discontinued Procedure										
24E	Diagnosis Pointer	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.									
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.									
24I	ID Qualifier	Optional. If possible, leave blank for Louisiana Medicaid billing.									
24J	Rendering Provider ID #	Leave Blank									
25	Federal Tax ID 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.									

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12


Locator #	Description	Instructions	Alerts
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of 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 (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.

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

Example of Billing 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) 02/02

PICA ☐ PICA ☐

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 BLK (UNG) <input type="checkbox"/> OTHER <input type="checkbox"/> (100)		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 MM DD YY 01 01 95 SEX F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 ANYLANE		7. INSURED'S ADDRESS (No., Street)	
CITY MYTOWN STATE LA		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:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL CODE IF APPLICABLE		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. INSURED'S DATE OF BIRTH MM DD YY SEX F <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		c. INSURED'S POLICY GROUP OR FECA NUMBER	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9b.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information related to this claim. I also request payment of common benefits for myself or for the party who so assigns.) SIGNED		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information related to this claim. I also request payment of common benefits for myself or for the party who so assigns.) SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, OR EVENT MM DD YY QUAL		15. DATE OF SERVICE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI		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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. O80 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B. BASIS OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OF SERVICE H. I. ID. NO. J. RENDERING PROVIDER ID #	
1 01 08 21 01 08 21 25 59409 A 950.00 1 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? YES NO		28. TOTAL CHARGE \$ 950.00 29. AMOUNT PAID \$	
30. 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 DATE 01/10/2021		31. BILLING PROVIDER INFO & PH# (225) 555-5555 EASY BIRTH, BIRTHING CENTER 500 W MAIN ST ANY TOWN, LA 70000	
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. 1234567890 c. 1987654		33. BILLING PROVIDER INFO & PH# (225) 555-5555 EASY BIRTH, BIRTHING CENTER 500 W MAIN ST ANY TOWN, LA 70000	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0338-1197 FORM 1500 (02-12)

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

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 internal 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.**

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.

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING**PAGE(S) 12**

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.

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

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

PICA ☐

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (ROM) <input type="checkbox"/> FECA (LUNG) (ROM) <input type="checkbox"/> OTHER <input type="checkbox"/>		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 MM 01 DD 01 YY 95 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (no., street) 1234 ANYLANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY MYTOWN STATE LA		7. INSURED'S ADDRESS (no., street) CITY STATE ZIP CODE 70000 TELEPHONE (include Area Code) (225) 999-7777	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL CODE IF APPLICABLE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. OTHER (Specify) (Designated by NUCC) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER (Specify) (Designated by NUCC) <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9c.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the use of medical services as undersigned physician or supplier for (attach doctor's book for signature) SIGNED 14. DATE OF CURRENT ILLNESS, INJURY, OR OTHER EVENT (MM/DD/YY) QUAL 15. DATE OF CURRENT OCCUPATION (MM/DD/YY) FROM TO 16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY) FROM TO 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. PRIOR AUTHORIZATION NUMBER 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (248) A. O76 B. C. D. E. F. G. H. I. J. K. L. 22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 1015198798700 23. PRIOR AUTHORIZATION NUMBER 24. A. DATE(S) OF SERVICE TO FROM B. A/R FOR SERVICE BKG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DATE OF LAST DATE H. EXPIRY DATE I. NO. OF QUIL J. REFERRING PROVIDER ID. #			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (YES/NO) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 550.00 29. AMOUNT PAID \$	
30. 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.) JOHN DOE, MD 02/11/2021 DATE		31. BILLING PROVIDER INFO & PH# (225) 555-5555 EASY BIRTH, BIRTHING CENTER 500 W MAIN ST ANY TOWN, LA 70000 a. 1234567890 b. 1987654	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0338-1197 FORM 1500 (02-12)

CHAPTER 28: FREE-STANDING BIRTHING CENTERS

APPENDIX B: CLAIMS FILING

PAGE(S) 12

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

<div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (ID#DoD#) (Member ID#) (ID#) (ID#)</small> </div> <div> FIGA <input type="checkbox"/> </div> </div>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
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"/>									
7. INSURED'S ADDRESS (No., Street)									
8. RESERVED FOR NUCC USE									
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									
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.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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									
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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate to service line below (24E)									
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPST/PAK Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX ID, NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Pwd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (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: #									
SIGNED DATE NPI FIGA									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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