CLAIMS FILING

Hard copy billing of Greater New Orleans Community Health Connection 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 www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "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 a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

CMS 1500 BILLING INSTRUCTIONS FOR GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION 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 #).	**GNOCHC providers should mark the Medicaid indicator.**
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit GNOCHC ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit ID number must 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.	**The 13-digit GNOCHC number and the 13-digit Medicaid number are the same number.**
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 (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 recipient.	
4	Insured's Name	**Leave Blank**	
5	Patient's Address	**Leave Blank**	
6	Patient Relationship to Insured	**Leave Blank**	
7	Insured's Address	**Leave Blank**	
8	RESERVED FOR NUCC USE		

Locator#	Description	Instructions	Alerts
9	Other Insured's Name	**Leave Blank**	
9a	Other Insured's Policy or Group Number	**Leave Blank**	
9b	RESERVED FOR NUCC USE	**Leave Blank**	
9c	RESERVED FOR NUCC USE	**Leave Blank**	
9d	Insurance Plan Name or Program Name	**Leave Blank**	
10 a. b. c.	Is Patient's Condition Related To: Employment Auto Accident Other Accident	**Situational** – Complete if the services are related to the patient's employment, an auto accident or another type of accident.	
11	Insured's Policy Group or FECA Number	**Leave Blank**	
11a	Insured's Date of Birth Sex	**Leave Blank**	
11b	OTHER CLAIM ID (Designated by NUCC)	**Leave Blank**	
11c	Insurance Plan Name or Program Name	**Leave Blank**	
11d	Is There Another Health Benefit Plan?	**Leave Blank**	

Locator#	Description	Instructions	Alerts
12	Patient's or Authorized Person's Signature (Release of Records)	**Leave Blank**	
13	Patient's or Authorized Person's Signature (Payment)	**Leave Blank**	
14	Date of Current Illness / Injury / Pregnancy	**Leave Blank**	
15	OTHER DATE	**Leave Blank**	
16	Dates Patient Unable to Work in Current Occupation	**Leave Blank**	
17	Name of Referring Provider or Other Source	**Leave Blank**	
17a	Unlabelled	**Leave Blank**	
17b	NPI	**Leave Blank**	
18	Hospitalization Dates Related to Current Services	**Situational –** Complete if appropriate or leave blank	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab?	**Leave Blank**	

Locator#	Description	Instructions	Alerts
21	ICD Ind. Diagnosis or Nature of Illness or Injury	**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 **Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description. **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.	**The most current and specific diagnosis code(s) must be entered.** **Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD-10-CM codes will be announced at a later date.**
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: <u>Adjustments</u> 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 00 = Other	**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).** **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.**

Locator#	Description	Instructions	Alerts
23	Prior Authorization Number	**Leave Blank**	
24	Supplemental Information	**Situational** – Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.** To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered in NDC UNITS**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units: F2 International Unit ML Milliliter GR Gram UN Unit	**All GNOCHC providers who administer drugs and biologicals must enter this drug-related information in the SHADED section of 24A – 24G of the appropriate detail line(s) for the drug or biological – not the encounter line.** **This information must be entered in addition to the procedure code(s) for all GNOCHC providers.** **Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units and entry of NDC numbers with less than 11 digits.**

<table>
<tr><th>Locator#</th><th>Description</th><th>Instructions</th><th>Alerts</th></tr>
<tr><td>24A</td><td>Date(s) of Service</td><td>Required -- Enter the date of service for each procedure.

Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</td><td>Six-digit or 8-digit dates can be used on paper claims.

Only 8-digit dates can be used for electronic (EDI) claims.</td></tr>
<tr><td>24B</td><td>Place of Service</td><td>Required -- Enter the appropriate place of service code for the services rendered.

Acceptable Place of Service Codes are:<table><tr><th>Code</th><th>Definition</th></tr><tr><td>04</td><td>Homeless Shelter</td></tr><tr><td>11</td><td>Office</td></tr><tr><td>12</td><td>Home</td></tr><tr><td>15</td><td>Mobile Unit</td></tr><tr><td>49</td><td>Independent Clinic</td></tr><tr><td>50</td><td>Federally Qualified Health Center</td></tr><tr><td>53</td><td>Community Mental Health Center</td></tr><tr><td>57</td><td>Non-Residential Substance Abuse Treatment Facility</td></tr><tr><td>71</td><td>State or Local Public Health Clinic</td></tr><tr><td>72</td><td>Rural Health Clinic</td></tr><tr><td>81</td><td>Independent Laboratory</td></tr></table></td><td>Claims submitted with no Place of Service Code
OR
a code other than one from this list will deny.</td></tr>
<tr><td>24C</td><td>EMG</td><td>Leave Blank</td><td></td></tr>
</table>

Locator#	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered. Enter the GNOCHC encounter procedure code on the first line. **Encounter Code = T1015** The appropriate modifier must be appended to the encounter code. The primary care encounter does not have a modifier. Use TF for the Basic Behavioral Health Encounter and TG for the SMI Behavioral Health Encounter. The primary care encounter and one behavioral health encounter may be billed on the same date of service if both types of visits occur. In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered. Report in the encounter each CPT code for covered services ordered by the participating provider and provided to the enrollee, whether provided directly by the participating provider or indirectly by referral and paid for by the participating provider (i.e., lab, radiology and specialty services	**The encounter code must be present on the claim, accompanied by at least 1 detail line for a covered service.** **All services should be included as detail lines.** **If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 is required.**
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.	

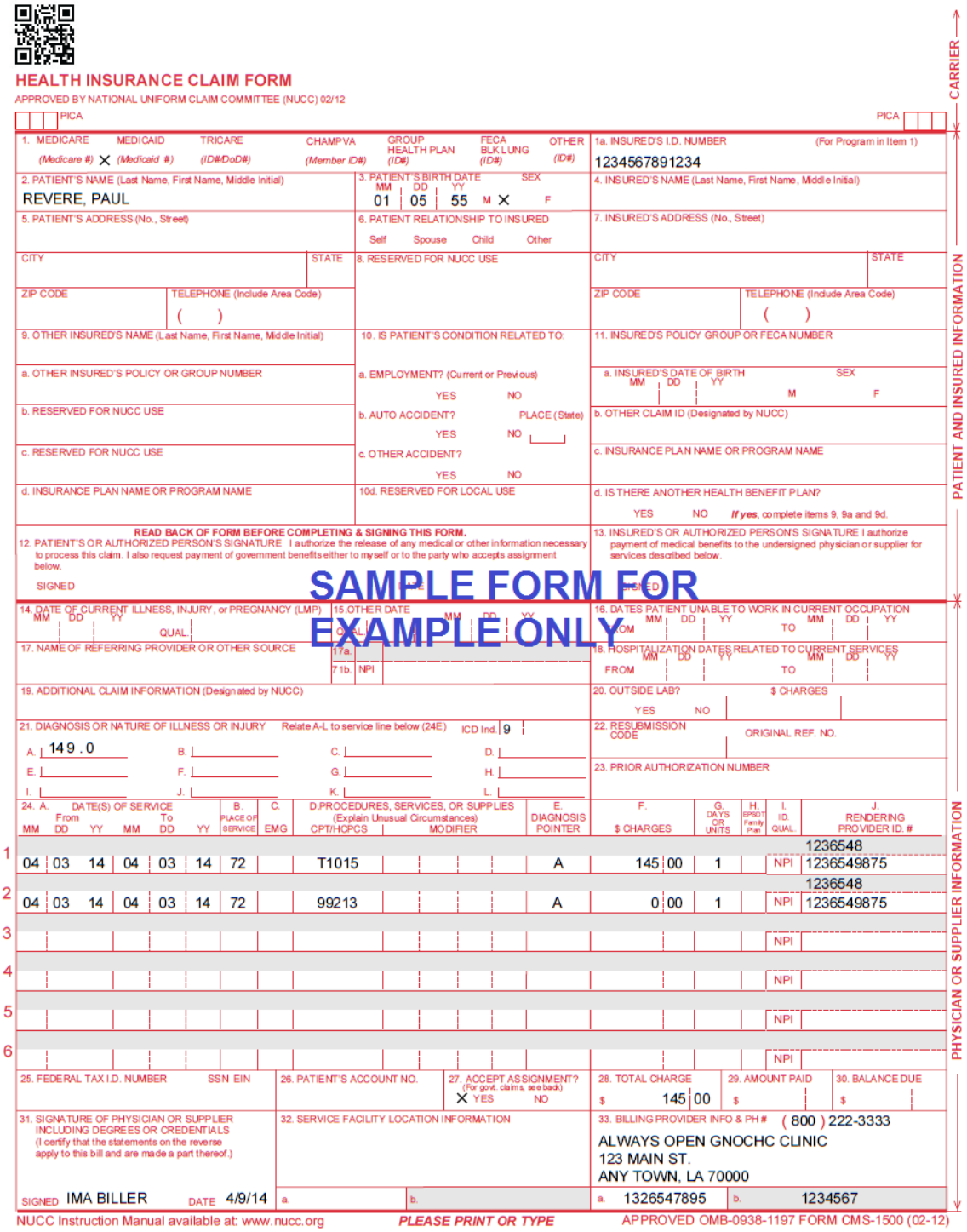
Locator#	Description	Instructions	Alerts
24F	$Charges	**Required** -- Enter usual and customary charge for encounter line and enter zero for detail lines.	**Claims will be paid at the lesser of the established encounter rate and the usual and customary charge entered for the encounter line.**
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	**Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units.**
24H	EPSDT Family Plan	**Leave Blank**	
24I	I.D. Qual.	**Optional -** The I.D. Qualifier indicates what type of identifying provider number is being entered in 24J.	**This field can be left blank for GNOCHC.**
24J	Rendering Provider I.D. #	**Required -** Enter the Rendering Provider's Medicaid Provider Number in the shaded portion of the block. Entering the Rendering Provider's NPI in the non-shaded portion of the block.	**An attending provider number/NPI must be entered.** **If the attending provider is a type that cannot enroll in Louisiana Medicaid, enter the GNOCHC billing provider number/NPI as the attending provider.** **If provider cannot be an attending provider, enter the GNOCHC billing provider number/NPI as the attending provider.**

Locator#	Description	Instructions	Alerts
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.	
27	Accept Assignment	**Leave Blank -** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Leave Blank**	
30	Rsvd 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	**Leave Blank**	
32a	NPI	**Leave Blank**	
32b	Unlabelled	**Leave Blank**	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	

Locator#	Description	Instructions	Alerts
33a	NPI	**Required** – Enter the GNOCHC billing provider's NPI.	
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit GNOCHC Provider Number. **ID Qualifier - Optional.** If possible, leave blank for Louisiana Medicaid billing.	**Claims will be rejected if this information is not present on the claim form.**

A sample form is on the following page

SAMPLE GNOCHC CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | 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): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REVERE, PAUL

3. PATIENT'S BIRTH DATE: 01 05 55 SEX: M X 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 SEX

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. RESERVED FOR LOCAL USE

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

SAMPLE FORM FOR EXAMPLE ONLY

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 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. 9

A. 149.0 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	04	03	14	04	03	14	72		T1015		A	145 00	1		NPI	1236548 1236549875
2	04	03	14	04	03	14	72		99213		A	0 00	1		NPI	1236548 1236549875
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) X YES NO

28. TOTAL CHARGE $ 145 00

29. AMOUNT PAID $

30. BALANCE DUE $

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 IMA BILLER DATE 4/9/14

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (800) 222-3333

ALWAYS OPEN GNOCHC CLINIC
123 MAIN ST.
ANY TOWN, LA 70000

a. 1326547895 b. 1234567

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ADJUSTMENTS AND VOIDS

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.

- 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.

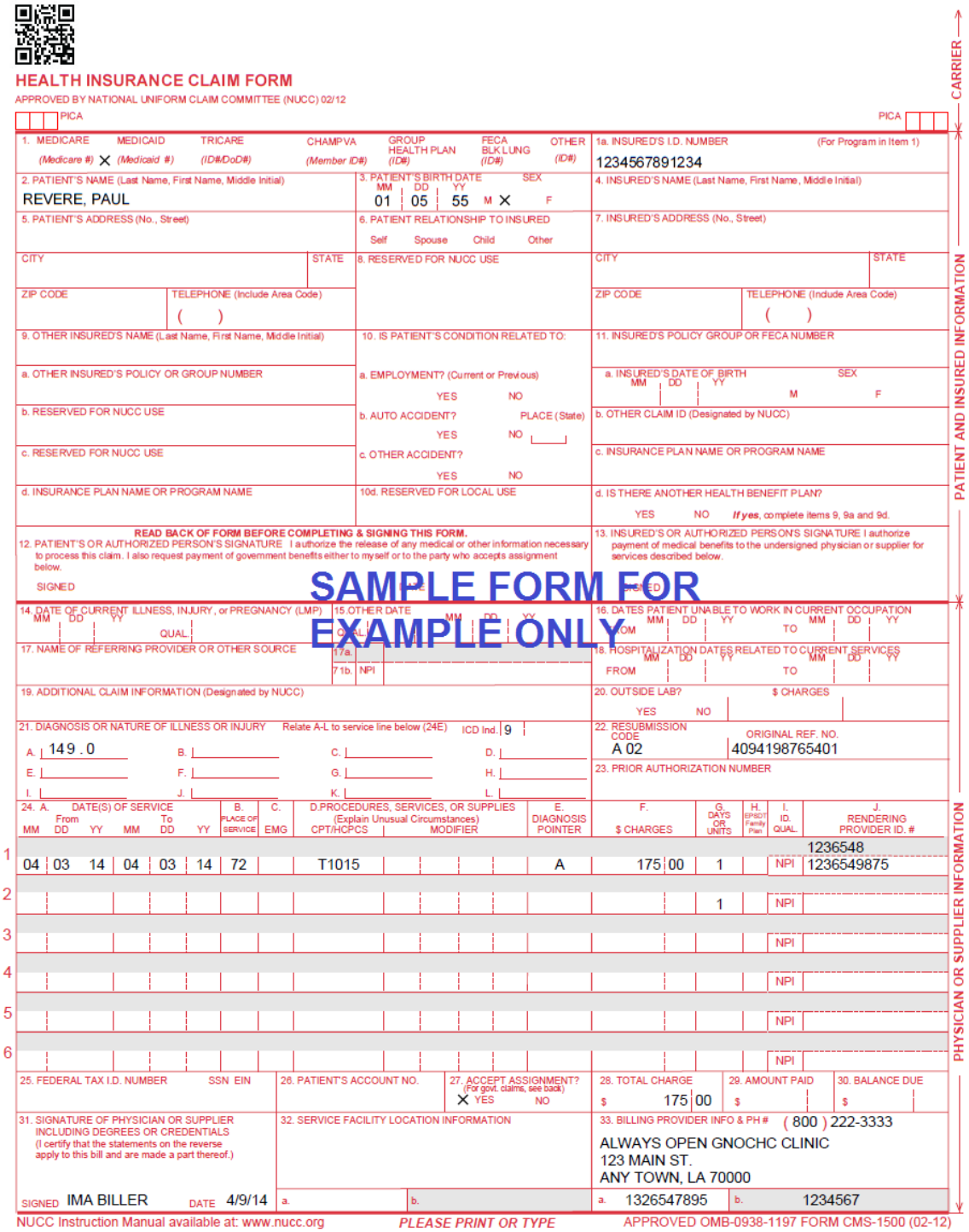
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

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

SAMPLE GNOCHC CLAIM FORM ADJUSTMENT



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | 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): 1234567891234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REVERE, PAUL

3. PATIENT'S BIRTH DATE MM DD YY: 01 05 55 SEX M X 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? 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. RESERVED FOR LOCAL USE

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

SAMPLE FORM FOR EXAMPLE ONLY

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. 9
A. 149.0 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 4094198765401

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	04 03 14	04 03 14	72		T1015		A	175 00	1		NPI	1236548 1236549875
2									1		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) X YES NO

28. TOTAL CHARGE $ 175 00

29. AMOUNT PAID $

30. BALANCE DUE $

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 IMA BILLER DATE 4/9/14

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # (800) 222-3333
ALWAYS OPEN GNOCHC CLINIC
123 MAIN ST.
ANY TOWN, LA 70000
a. 1326547895 b. 1234567

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION