
CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

CLAIMS RELATED INFORMATION

Hard copy billing of Personal Care Services (PCS) are billed on the CMS-1500 (02/12) claim form or electronically in 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

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
2. 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 Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

CMS 1500 (02/12) Billing Instructions for Personal Care 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 #).	
1a	Insured's I.D. Number	Required – Enter the beneficiary's 13-digit Medicaid I.D. number exactly as it appears when checking beneficiary eligibility through MEVS, eMEVS, or REVS. NOTE: 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 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.	
3	Patient's Birth Date Sex	Required – 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	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

Locator #	Description	Instructions	Alerts
5	Patient's Address	Optional – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	Leave Blank.	
9	Other Insured's Name	Situational – Complete if appropriate or 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	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.	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

Locator #	Description	Instructions	Alerts
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Leave Blank.	
17	Name of Referring Provider or Other Source	<p>Situational – Complete if applicable. Enter the applicable qualifier to the left of the vertical, dotted line to Identify which provider is being reported.</p> <p>o DK Ordering Provider</p> <p>In the following circumstances, entering the name (First Name, Middle Initial, Last Name) followed by the credentials of the ordering physician or non-physician practitioner and appropriate qualifier is required:</p> <ul style="list-style-type: none"> • EPSDT - PCS Services always require an ordering provider 	<p>For LA Medicaid other source is defined as the ordering provider.</p> <p>Any provider entered as an ordering provider must be enrolled with LA Medicaid.</p> <p>Note: LTPCS does not require an ordering provider but if no one is listed on the claim, it must be valid.</p>

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

Locator #	Description	Instructions	Alerts
17a	Other ID #	Situational Complete if applicable. Enter the 7-digit Medicaid ID number of the ordering provider.	Enter the 7- digit Medicaid ID Number here.
17b	NPI#	Situational – Complete if applicable. Enter the NPI number of the ordering provider.	The 10-digit NPI Number is <u>required</u> .
18	Hospitalization Dates Related to Current Services	Optional.	
19	Additional Claim Information (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Leave Blank.	
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>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.</p> <p>0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p> <p>NOTE: ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as <u>non-primary</u> diagnosis codes</p>	The most specific diagnosis codes must be used. General codes are not acceptable.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

Locator #	Description	Instructions	Alerts
22	Resubmission Code 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 “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 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 (PA) Number	Required – Enter the 9-digit prior authorization number for the authorized services.	
24	Supplemental Information	Situational.	
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	Required -- Enter the appropriate place of service code for the services rendered.	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

Locator #	Description	Instructions	Alerts
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered in the unshaded area(s).</p> <p>Enter appropriate modifier with procedure code:</p> <p>UB = LT-PCS EP = EPSDT-PCS</p>	
24E	Diagnosis Pointer	<p>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number 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	\$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	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank.	
25	Federal Tax I.D. Number	Optional.	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	Situational – 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?	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	Leave Blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Practitioner or Supplier Including Degrees or Credentials Date	Optional – For the PCS CMS 1500, 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	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required – Enter the billing provider's 10-digit NPI number.	The 10-digit NPI Number must appear on paper claims.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14


Locator #	Description	Instructions	Alerts
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 <u>must</u> appear on paper claims.

Sample PCS Claim Form – See below.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

 **HEALTH INSURANCE CLAIM FORM**
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ PICA ☒ PICA

Mail completed forms to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

1. MEDICAID ☒ **MEDICAID** ☐ **TRICARE** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN** ☐ **BECA/SEKUNG** ☐ **OTHER** ☐

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

3. PATIENT'S BIRTH DATE MM DD YY
06 11 05

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
1234567890123

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

6. PATIENT RELATIONSHIP TO INSURED
Self ☒ Spouse ☐ Child ☐ Other ☐

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

8. RESERVED FOR NUCC USE

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

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
b. AUTO ACCIDENT? YES ☐ NO ☐
c. OTHER ACCIDENT? YES ☐ NO ☐

11. INSURED'S POLICY GROUP OR BECA 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.
SIGNED: DATE: 03/08/19

13. INSURED'S DATE OF BIRTH MM DD YY
SEX: F ☒ M ☐

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY
QUAL: 1234567

15. OTHER DATE MM DD YY
QUAL: 1234567890

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 | JOHN 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 Please A-L to service line below (24E)
A. G808 B. C. D. E. F. G. H. I. J. K. L. ICD Ind: 0

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
123456789

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY
B. PLACE OF SERVICE
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
E. DIAGNOSIS POINTER
F. \$ CHARGES
G. DAYS OF ILLNESS
H. EFFECTIVE DATE
I. ID QUAL
J. REFERRING PROVIDER ID #

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For group claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE \$ 165.00
29. AMOUNT PAID \$
30. Rev'd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)
IMMA BILLER
DATE: 03/08/19

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b. 1987654

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

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMS-0935-1197 FORM 1500 (02-12)

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

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 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.**

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14

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 PCS Claim Form Adjustment Form – See below.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14



HEALTH INSURANCE CLAIM FORM

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

PICA

Mail completed forms to:

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

PICA

1. MEDICAID (Medicaid) <input checked="" type="checkbox"/> (Medicare) <input type="checkbox"/> TRI-CARE (IC/Medicaid) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA EMPLOYING (ID#) <input type="checkbox"/> OTHER (ID#) <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) LOU, JANNIE		3. PATIENT'S BIRTH DATE MM DD YY 06 11 05 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	
ZIP CODE 70000		TELEPHONE (Include Area Code) (225) 999-7777	
3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. OTHER INSURED'S POLICY OR GROUP NUMBER		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 DATE OF BIRTH MM DD YY SEX F <input type="checkbox"/> M <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL _____		15. OTHER DATE MM DD YY QUAL _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JOHN DOE, MD		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17a. NPI 1234567 17b. NPI 1234567890	
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. Refer to A-L to service line below. (IAC Ind.) 0 A. G808 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 9070123456002	
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/NO/PCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. PAID IN FULL H. SPOT SERVICE PLAN I. ID. QUAL J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER PA # IF APPLICABLE	
1 03 01 19 03 01 19 12 T1019 EP A 42.00 14 NPI		25. FEDERAL TAX I.D. NUMBER SSN/ EIN 26. PATIENT'S ACCOUNT NO. 1234 27. ACCEPT ASSIGNMENT? (For great claims, see back) X YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 42.00 29. AMOUNT PAID \$ 30. Resd 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 hereof.) IMMA BILLER 03/29/19 SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____	
33. BILLING PROVIDER INFO & PH# (800) 233-3333 PCS AGENCY 700 MAIN ST ANY TOWN, LA 70000 a. 1326547895 b. 1987654			

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CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

PAGE(S) 14



HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> SEX <input type="checkbox"/> LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Programs 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 STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code)										CITY STATE									
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										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. 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.										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 DATE										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 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 A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. B. C. D. E. F. G. H. I. J. K. L.										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. EST. Rpt. 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.									
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.)										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED DATE										33. BILLING PROVIDER INFO & PH # ()									
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