CLAIMS RELATED INFORMATION

Hard copy billing of professional services are billed on the paper CMS-1500 (02/12) claim form or billed 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:

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 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:

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

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

CMS 1500 (02/12) INSTRUCTIONS FOR PROFESSIONAL SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's ID 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 beneficiaries' 13-digit Medicaid ID number must be used to bill claims. The card control number (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	**Situational** – 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.	
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 NUCC USE	**Leave Blank.**	
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 insurance 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 Medicaid Eligibility Verification (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 HMO's 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.	
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.	

Locator #	Description	Instructions	Alerts
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.**	

Locator #	Description	Instructions	Alerts
17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable. 1. In the following circumstances, entering the name, National Provider Identifier (NPI) and credentials of the appropriate physician or non-physician practitioner and appropriate qualifier is required: If services are performed at the request of an ordering or referring practitioner: Enter the applicable qualifier to the left of the vertical, dotted line to identify the practitioner being reported is either 1. DK= Ordering Provider 2. or 3. DN= Referring Provider 2. Enter the name (First Name, Middle Initial, Last Name) followed by the credential of the physician or non-physician practitioner who ordered or referred the service(s) or supply(ies) on the claim. Examples of services requiring Ordering Provider (DK qualifier) 1. Services performed by an independent laboratory 2. Diagnostic testing 3. Services performed by a pediatric day health care clinic 4. Services are for DME. Examples of services requiring Referring Provider: 1. If the beneficiary is a lock-in beneficiary and has been referred to the billing provider for services, enter the lock-in physician's name. 2. If the beneficiary was referred to the billing provider for chiropractic services. 3. If ACA services are delivered by a PA or APRN, the name of the supervising ACA certified physician is required in this field.	**For LA Medicaid "Other Source" is defined as the ordering provider or referring provider.**

Locator #	Description	Instructions	Alerts
17a	Other ID#	**Situational** – Complete if applicable. If 17 is completed, 17A is **Required.**	**Enter the 7-digit Medicaid ID Number here.**
17b	NPI	**Situational** – Complete if applicable. If 17 is completed, 17B is **Required.**	**The 10-digit NPI Number is required when 17 or 17A is complete**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab? $Charges	**Optional.**	
21	ICD Indicator 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. 0 ICD-10-CM **Required** -- Enter the most current ICD diagnosis code. NOTE: ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as non-primary diagnosis codes.	**The most specific diagnosis codes must be used. General codes are not acceptable**

Locator #	Description	Instructions	Alerts
22	Resubmission Code 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 "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 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	**Situational** – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the PA number is **required** to be entered.	

Locator #	Description	Instructions	Alerts
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 **11 digit 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 and 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 shall be used when reporting NDC units: 1. F2=International Unit 2. ML=Milliliter 3. GR=Gram 4. UN=Unit	**Physicians and other provider types who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A-24G of the appropriate detail lines only.** **This information must be entered in addition to the procedure code(s).** **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.**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure billed. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	

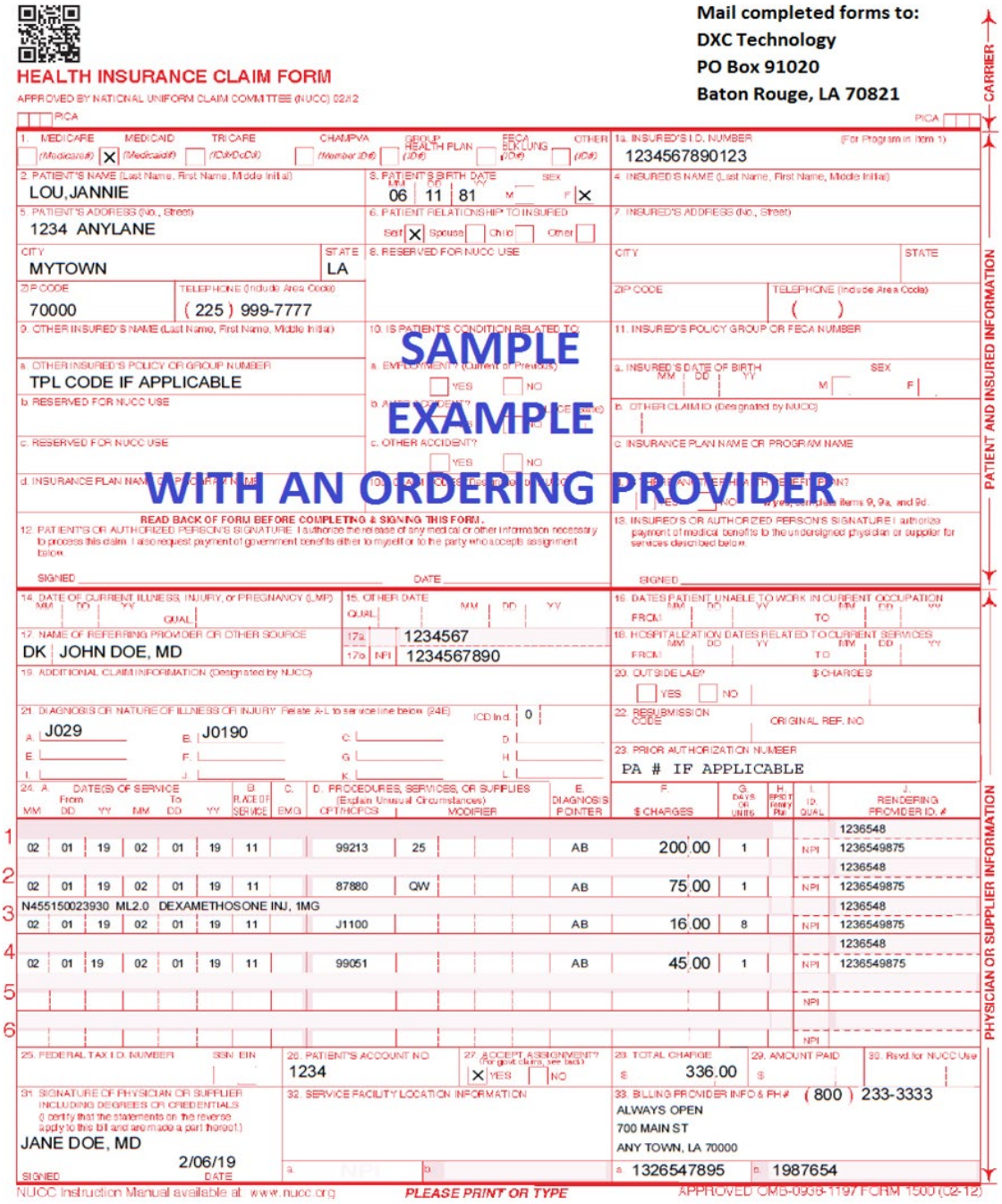
Locator #	Description	Instructions	Alerts
24C	EMG	**Situational** – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
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.	
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	**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	**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#	**Situational** – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is **required**. Entering the Rendering Provider's NPI in the non-shaded portion of the block is **required** if the shaded portion is complete.	**Both the 7-digit Medicaid provider number and the 10-digit NPI numbers are required when entering a rendering provider.** **Rendering =Attending**

Locator #	Description	Instructions	Alerts
25	Federal Tax IDNumber	**Optional.**	
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	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by primary payor. Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare payments in this field.**	**Do not report Medicare or Medicare Replacement plan payments in this field.**
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	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	
32b	Other ID#	**Situational –** Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	**Required** -- Enter the provider name, address including zip code and telephone number.	

Locator #	Description	Instructions	Alerts
33a	NPI	**Required –** Enter the billing provider's 10-digit NPI number**.**	**The 10-digit NPI Number must appear on paper claims.**
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.**

Sample forms are on the following pages

SAMPLE PROFESSIONAL CLAIM FORM



Mail completed forms to:
DXC Technology
PO 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): 123456890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU, JANNIE
3. PATIENT'S BIRTH DATE MM DD YY: 06 11 81 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. 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.

SAMPLE
EXAMPLE
WITH AN ORDERING PROVIDER

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 TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JOHN DOE, MD
17a: 1234567
17b NPI: 1234567890
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. 0
A. J029 B. J0190 C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: PA # IF APPLICABLE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	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	02	01	19	02	01	19	11		99213	25		AB	200.00	1		NPI	1236548 1236549875
2	02	01	19	02	01	19	11		87880	QW		AB	75.00	1		NPI	1236548 1236549875
3	N455150023930 ML2.0 DEXAMETHOSONE INJ, 1MG																
	02	01	19	02	01	19	11		J1100			AB	16.00	8		NPI	1236548 1236549875
4	02	01	19	02	01	19	11		99051			AB	45.00	1		NPI	1236548 1236549875
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO
28. TOTAL CHARGE: $ 336.00
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.)
JANE DOE, MD
SIGNED 2/06/19 DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # (800) 233-3333
ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
CARRIER

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

ADJUSTING/VOIDING CLAIMS

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

Only a paid claim may be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line may 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; or

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. Those claims 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.

Sample forms are on the following pages.

SAMPLE PROFESSIONAL CLAIM FORM ADJUSTMENT

Mail completed forms to:
Gainwell Technologies
PO 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)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
LOU, JANNIE			06 11 81	M F X					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
1234 ANYLANE			Self X Spouse Child Other						
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE
MYTOWN		LA							
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
70000	(225) 999-7777							( )	
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)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
TPL CODE IF APPLICABLE			YES NO					M F	
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)		
			YES NO						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES NO						
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 TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1234567		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY		
DK JOHN DOE, MD	17b. NPI 1234567890				
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. 0			22. RESUBMISSION CODE A 02	ORIGINAL REF. NO. 9038012345602	
A. J029 B. J0190 C. D.			23. PRIOR AUTHORIZATION NUMBER		
E. F. G. H.			PA # IF APPLICABLE		
I. J. K. L.					

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 02 01 19	02 01 19	11		87880	QW	AB	50 00	1			1236548
										NPI	1236549875
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)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd. for NUCC Use
	1234	X YES NO	$ 50.00	$	

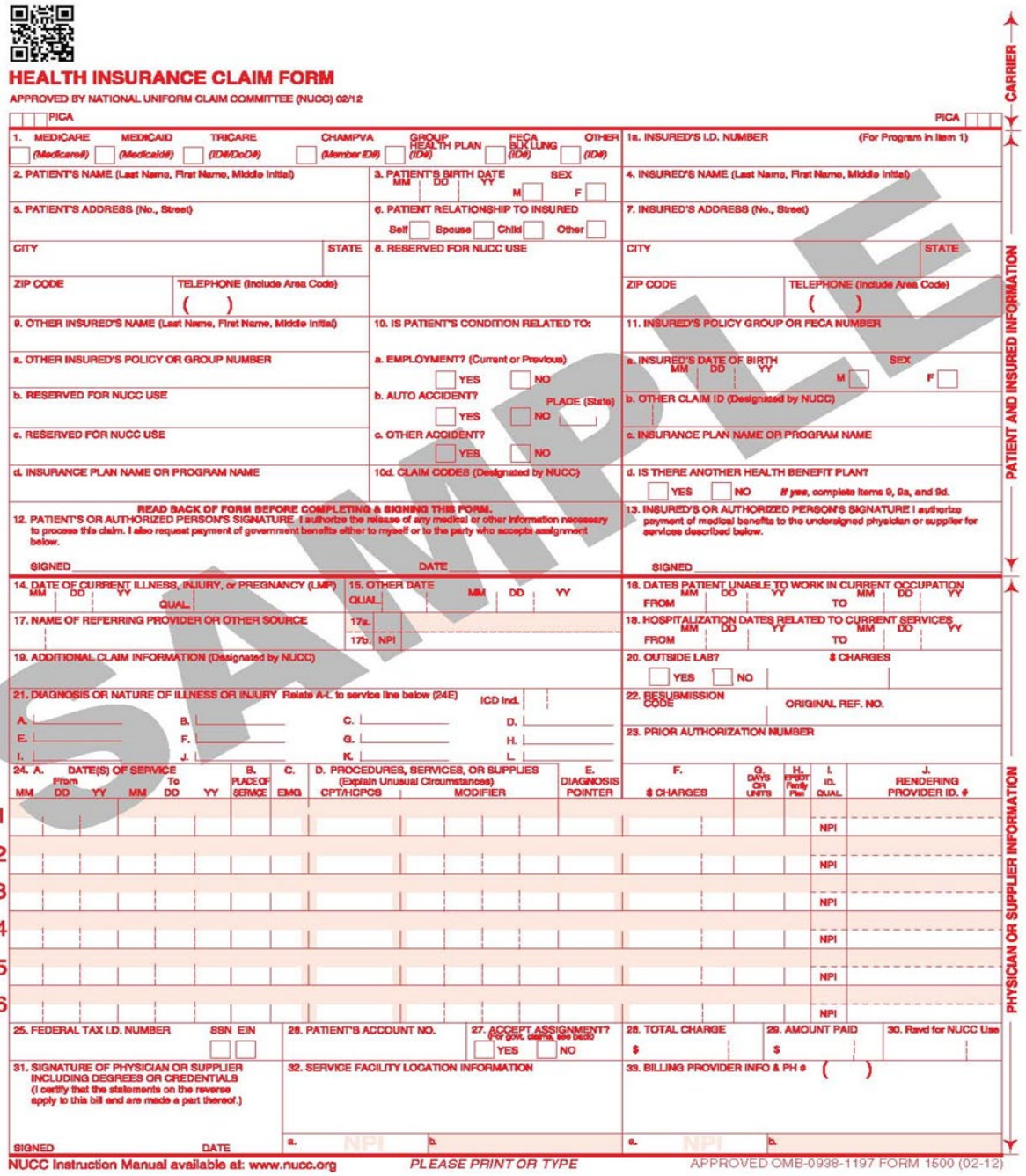
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (800) 233-3333
JANE DOE, MD		ALWAYS OPEN
2/28/19	a. NPI b.	700 MAIN ST
SIGNED DATE		ANY TOWN, LA 70000
		a. 1326547895 b. 1987654

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE
EXAMPLE
WITH AN ORDERING PROVIDER

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.

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