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### CLAIMS FILING

Hard copy billing of waiver 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 <u>www.lamedicaid.com</u>, 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; and
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

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### CMS 1500 (02/12) INSTRUCTIONS FOR SUPPORTS WAIVER SERVICES

| Locator # | Description   | Instructions   | Alerts   |
|-----------|---|--|--|
| 1         | Medicare / Medicaid /<br>Tricare Champus /<br>Champva /<br>Group Health Plan /<br>Feca Blk Lung | <b>Required</b> Enter an "X" in the box marked Medicaid (Medicaid #).  | You must write "WAIVER"<br>at the top center of the<br>Louisiana Medicaid claim<br>form. |
| 1a        | Insured's ID Number   | Required – Enter the recipient's 13-digit Medicaid<br>ID number exactly as it appears when checking<br>recipient eligibility through MEVS, eMEVS, or<br>REVS.<br>NOTE: The recipients' 13-digit Medicaid ID<br>number must be used to bill claims. The CCN<br>number from the plastic ID card is NOT<br>acceptable. The ID number must match the<br>recipient's name in Block 2. |  |
| 2         | Patient's Name  | <b>Required</b> – Enter the recipient's last name, first name, middle initial.   |  |
| 3         | Patient's Birth Date<br>Sex   | Situational – Enter the recipient's date of birth<br>using six digits (MM DD YY). If there is only one<br>digit in this field, precede that digit with a zero (for<br>example, 01 02 07).<br>Enter an "X" in the appropriate box to show the<br>sex of the recipient.  |  |
| 4         | Insured's Name  | Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.   |  |
| 5         | Patient's Address   | <b>Optional</b> – Print the recipient's permanent address.   |  |
| 6         | Patient's Relationship to<br>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<br>USE                  |  |  |
| 9         | Other Insured's Name                      | Situational – Complete if appropriate or leave blank.  |  |
| 9a        | Other Insured's Policy or<br>Group Number | Situational – If recipient has no other coverage,<br>leave blank.<br>If there is other commercial insurance coverage,<br>the state assigned 6-digit TPL carrier code is<br>required in this block. The carrier code is<br>indicated on the Medicaid Eligibility verification<br>(MEVS) response as the Network Provider<br>Identification Number.<br>Make sure the EOB or EOBs from other<br>insurance(s) are attached to the claim. | ONLY the 6-digit code<br>should be entered in this<br>field. DO NOT enter<br>dashes, hyphens, or the<br>word TPL in the field. |
| 9b        | RESERVED FOR NUCC<br>USE                  | Leave Blank.   |  |
| 9с        | RESERVED FOR NUCC<br>USE                  | Leave Blank.   |  |
| 9d        | Insurance Plan Name or<br>Program Name    | Situational – Complete if appropriate or leave blank.  |  |
| 10        | Is Patient's Condition<br>Related To:     | Situational – Complete if appropriate or leave blank.  |  |
| 11        | Insured's Policy Group or<br>FECA Number  | Situational – Complete if appropriate or leave blank.  |  |
| 11a       | Insured's Date of Birth<br>Sex            | Situational – Complete if appropriate or leave blank.  |  |

| Locator # | Description   | Instructions  | Alerts |
|-----------|---|---|--------|
| 11b       | OTHER CLAIM ID<br>(Designated by NUCC)                                | Leave Blank.  |        |
| 11c       | Insurance Plan Name or<br>Program Name                                | Situational – Complete if appropriate or leave blank.         |        |
| 11d       | Is There Another Health<br>Benefit Plan?                              | Situational – Complete if appropriate or leave blank.         |        |
| 12        | Patient's or Authorized<br>Person's Signature<br>(Release of Records) | Situational – Complete if appropriate or leave blank.         |        |
| 13        | Insured's or Authorized<br>Person's Signature<br>(Payment)            | Situational – Obtain signature if appropriate or leave blank. |        |
| 14        | Date of Current Illness /<br>Injury / Pregnancy                       | Optional.   |        |
| 15        | OTHER DATE  | Leave Blank.  |        |
| 16        | Dates Patient Unable to<br>Work in Current<br>Occupation              | Optional.   |        |
| 17        | Name of Referring<br>Provider or Other Source                         | Situational – Complete if applicable.                         |        |
| 17a       | Unlabeled   | Situational – Complete if applicable.                         |        |
| 17b       | NPI   | Situational – Complete if applicable.                         |        |

| Locator # | Description  | Instructions   | Alerts   |
|-----------|--|--|--|
| 18        | Hospitalization Dates<br>Related to Current<br>Services      | Optional.  |  |
| 19        | ADDITIONAL CLAIM<br>INFORMATION<br>(Designated by NUCC)      | Leave Blank.   |  |
| 20        | Outside Lab?   | Optional.  |  |
| 21        | ICD Indicator<br>Diagnosis or Nature of<br>Illness or Injury | Required – Enter the applicable ICD indicator to<br>identify which version of ICD coding is being<br>reported between the vertical, dotted lines in the<br>upper right-hand portion of the field.<br>9 ICD-9-CM<br>0 ICD-10-CM<br>Required – Enter the most current ICD diagnosis<br>code.<br>NOTE: The ICD-9-CM "E" and "M" series<br>diagnosis codes are not part of the current<br>diagnosis file and should not be used when<br>completing claims to be submitted to Medicaid. | The most specific diagnosis<br>codes must be used. General<br>codes are not acceptable.<br>ICD-9 diagnosis codes<br>must be used on claims<br>for dates of service prior<br>to 10/1/15.<br>ICD-10 diagnosis codes<br>must be used on claims<br>for dates of service on or<br>after 10/1/15.<br>Refer to the provider<br>notice concerning the<br>federally required<br>implementation of ICD-10<br>coding which is posted on<br>the ICD-10 Tab at the top<br>of the Home page<br>(www.lamedicaid.com). |

# CHAPTER 43: SUPPORTS WAIVER APPENDIX E – CLAIMS FILING

| Locator # | Description                   | Instructions   | Alerts   |
|-----------|-------------------------------|--|--|
| 22        | Resubmission Code             | Situational. If filing an adjustment or void, enter<br>an "A" for an adjustment or a "V" for a void as<br>appropriate AND one of the appropriate reason<br>codes for the adjustment or void in the "Code"<br>portion of this field.         Enter the internal control number from the paid<br>claim line as it appears on the remittance advice<br>in the "Original Ref. No." portion of this field.         Appropriate reason codes follow:         Adjustments<br>01 = Third Party Liability Recovery<br>02 = Provider Correction<br>03 = Fiscal Agent Error<br>90 = State Office Use Only – Recovery<br>99 = Other         Voids<br>10 = Claim Paid for Wrong Recipient<br>11 = Claim Paid for Wrong Provider<br>00 = Other | Effective with date of<br>processing 5/19/14,<br>providers currently using<br>the proprietary 213<br>Adjustment/Void forms will<br>be required to use the CMS<br>1500 (02/12).<br>To adjust or void more than<br>one claim line on a claim, a<br>separate form is required<br>for each claim line since<br>each line has a different<br>internal control number. |
| 23        | Prior Authorization<br>Number | <b>Required</b> – Enter the 9-Digit PA number in this field.   |  |
| 24        | Supplemental<br>Information   | Situational  |  |
| 24A       | Date(s) of Service            | Required Enter the date of service for each<br>procedure.<br>Either six-digit (MM DD YY) or eight-digit (MM DD<br>YYYY) format is acceptable.  |  |
| 24B       | Place of Service              | <b>Required</b> Enter the appropriate place of service code for the services rendered.   |  |
| 24C       | EMG                           | Leave Blank.   |  |

| Locator # | Description                          | Instructions   | Alerts  |
|-----------|--------------------------------------|--|---|
| 24D       | Procedures, Services, or<br>Supplies | <b>Required</b> Enter the procedure code(s) for<br>services rendered in the un-shaded area(s).<br>If a modifier(s) is required, enter the appropriate<br>modifier in the correct field.  |   |
| 24E       | Diagnosis Pointer                    | <b>Required</b> – Indicate the most appropriate<br>diagnosis for each procedure by entering the<br>appropriate reference letter ("A", "B", etc.) in this<br>block.<br>More than one diagnosis/reference number may   |   |
|           |                                      | be related to a single procedure code.   |   |
| 24F       | Amount Charged                       | <b>Required</b> Enter usual and customary charges for the service rendered.  |   |
| 24G       | Days or Units                        | <b>Required</b> Enter the number of units billed for<br>the procedure code entered on the same line in<br>24D  |   |
| 24H       | EPSDT Family Plan                    | Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.  |   |
| 241       | ID Qual.                             | <b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.  |   |
| 24J       | Rendering Provider ID#               | Situational – If appropriate, entering the<br>Rendering Provider's 7-digit Medicaid Provider<br>Number in the shaded portion of the block is<br>required.<br>Entering the Rendering Provider's NPI in the non-<br>shaded portion of the block is optional. | In instances where the<br>billing provider is required<br>to link attending providers<br>of services, entering the<br>attending provider Medicaid<br>ID number is required. |
| 25        | Federal Tax ID Number                | Optional.  |   |
| 26        | Patient's Account No.                | Situational – Enter the provider specific identifier<br>assigned to the recipient. This number will appear<br>on the Remittance Advice (RA). It may consist of<br>letters and/or numbers and may be a maximum of<br>20 characters.                         |   |

### **PAGE(S) 16**

| Locator # | Description   | Instructions   | Alerts  |
|-----------|---|--|---|
| 27        | Accept Assignment?  | <b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.  |   |
| 28        | Total Charge  | <b>Required</b> – Enter the total of all charges listed on the claim.  |   |
| 29        | Amount Paid   | Situational – If TPL applies and block 9A is comple<br>enter the amount paid by the primary payor (includir<br>contracted adjustments). Enter '0' if the third party d<br>pay.<br>If TPL does not apply to the claim, leave blank. | ng any  |
| 30        | RESERVED FOR NUCC<br>USE  | Leave Blank.   |   |
| 31        | Signature of Physician or<br>Supplier Including<br>Degrees or Credentials | <b>Optional</b> The practitioner or the practitioner's auth<br>representative's original signature is no longer requi  |   |
|           | Date  | Required Enter the date of the signature.  |   |
| 32        | Service Facility Location<br>Information                                  | Situational – Complete as appropriate or leave blar  | nk.   |
| 32a       | NPI   | Optional.  |   |
| 32b       | Unlabeled   | Situational – Complete if appropriate or leave blank   | κ.  |
| 33        | Billing Provider Info & Phone #   | Required Enter the provider name, address inclue code and telephone number.  | ding zip  |
| 33a       | NPI   | Optional.  |   |
| 33b       | Umlabeled   | Required – Enter the billing provider's 7-digit Medic<br>number.<br>ID Qualifier - Optional. If possible, leave blank for<br>Louisiana Medicaid billing.   | aid ID The 7-digit<br>Medicaid Provider<br>Number <u>must</u><br>appear on paper<br>claims. |

### REMINDER: MAKE SURE "WAIVER" IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

### Sample forms are on the following pages

## CHAPTER 43: SUPPORTS WAIVER APPENDIX E – CLAIMS FILING

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#### SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/01/15)

| HEALTH INSURANCE CLAIM FORM  | I  | WA  | IVER   |   |                                  |
|--|--|---|--|---|----------------------------------|
| PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (N   |  |   |  |   | PICA                             |
| 1. MEDICARE MEDICAID TRICARE   | CHAMPVA  | GROUP<br>HEALTH PLAN  | FECA OTHER<br>BLK LUNG   | 1a. INSURED'S I.D. NUMBER (For P  | rogram in Item 1)                |
| (Medicare #) X (Medicaid #) (ID#/DoD#)<br>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  | (Member ID#                                      | f) (ID#)  | (ID#) (ID#)  | 9876543210123<br>4. INSURED'S NAME (Last Name, First Name, Middle In  | - D                              |
| JAYCO, TRAVIS  |  | 07 31 72  | MX F   | 4. INSURED S NAME (Last Name, First Name, Middle Ini  | ear)                             |
| . PATIENT'S ADDRESS (No., Street)  | 6  | 3. PATIENT RELATION   | SHIP TO INSURED  | 7. INSURED'S ADDRESS (No., Street)  |                                  |
| тү   | STATE 8  | Self Spouse   | Child Other  | слу   | STATE                            |
|  | STATE  | RESERVED FOR NOC  | C USE  |   | SIALE                            |
| IP CODE TELEPHONE (Include Area  | Code)  |   |  | ZIP CODE TELEPHONE (Indude  | Area Code)                       |
| OTHER INSURED'S NAME (Last Name, First Name, Middle  | e Initial)                                       | 10. IS PATIENT'S CON  | DITION RELATED TO:   | ( )<br>11. INSURED'S POLICY GROUP OR FECA NUMBER  |                                  |
| C In Ex Indones C Invine (Las Hanne, Tha Hanne, Micco  | C Triting  |   | BINORIALBATED TO:  |   |                                  |
| OTHER INSURED'S POLICY OR GROUP NUMBER   | 4  | a. EMPLOYMENT? (Cur   |  | MM DD YY  | EX                               |
| PL Code if applicable RESERVED FOR NUCC USE  |  | YES   | NO<br>PLACE (State)  | b. OTHER CLAIM ID (Designated by NUCC)  | F                                |
|  | ľ  | SAN   |  |   |                                  |
| RESERVED FOR NUCC USE  |  | OTHER ACCIDENT?   |  | C. INSURANCE PLAN NAME OR PROGRAM NAME  |                                  |
| INSURANCE PLAN NAME OR PROGRAM NAME  |  | YES   |  | NUMERIC NOTHER HEALTH BENEFIT PLAN?   |                                  |
|  | ΞΧΑ  | MPLE  | E OF IC  | YES NO If yes complete items 9 (  | Ra and 9d                        |
| READ BACK OF FORM BEFORE OF<br>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE  | authorize the re                                 | lease of any medical or   | other information necessary  | <ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATU<br/>payment of medical benefits to the undersigned physic</li> </ol>  |                                  |
| to process this claim. I also request payment of government b<br>below.  | benefits either to                               | myself or to the party wh   | o accepts assignment   | services described below.   |                                  |
| SIGNED   |  | DATE  |  | SIGNED  |                                  |
| DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY  |  | HER DATE MM   | DD YY  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT   | DCCUPATION                       |
| QUAL.  | QUAL<br>E 17a.                                   |   |  | FROM TO<br>18. HOSPITALIZATION DATES RELATED TO CURRENT   | T SERVICES                       |
|  |  | NPI   |  | FROM DD YY MM   | DD YY                            |
| ADDITIONAL CLAIM INFORMATION (Designated by NUC  | :C)  |   |  | 20. OUTSIDE LAB? \$ CHARGES   |                                  |
| DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R   | elate A-L to serv                                | ice line below (24E)  | CD Ind. 9  | YES NO<br>22. RESUBMISSION<br>CODE ORIGINAL REF. NO.  |                                  |
| . 3510 в   | C.   |   | D.   | CODE ORIGINAL REF. NO.  |                                  |
| EL EL  | G  |   | н  | 23. PRIOR AUTHORIZATION NUMBER  |                                  |
|  |  |   |  | 4123123123  |                                  |
| J  | K.   | URES SERVICES OR  | L. F   | E G H I   | 1                                |
| I. A. DATE(S) OF SERVICE B. C.<br>From To PLACE OF   | D.PROCED   | URES, SERVICES, OR<br>in Unusual Circumstanc<br>S MODIFI                      | es) DIAGNOSIS  | F. G. H. I.<br>DAYS BOOT ID.<br>CR Family<br>VINTS Plan QUAL. P   | J.<br>RENDERING<br>ROVIDER ID. # |
| J. L. J. J. L. J. J. J. L. J.  | D.PROCED<br>(Expla<br>CPT/HCPC                   | in Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>ER POINTER  | CHARGES UNITS Part QUAL. P  | RENDERING                        |
| J. L. J. DATE(S) OF SERVICE B. C. PLACE OF FROM DO YY MM DD YY SERVICE EMG   | D.PROCED<br>(Expla                               | in Unusual Circumstanc  | es) DIAGNOSIS  | DAYS EPSOT ID   | RENDERING                        |
| J.         J.           A.         DATE(S) OF SERVICE         B.         C.           From         To         YV         PLACE OF           M         DD         YY         MM         DD         YY         EMG           3         31         14         03         31         14         12   | D.PROCED<br>(Expla<br>CPT/HCPC                   | in Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>ER POINTER  | CHARGES UNITS Part QUAL. P  | RENDERING                        |
| J.         J.           A.         DATE(S) OF SERVICE         B.         C.           From         To         YV         PLACE OF           M.         DD         YY         SERVICE         EMG           3         31         14         03         31         14         12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | In Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>POINTER<br>A  | S CHARGES         DAYS         IPMOT         ID.         P           90         00         30         NPI         P           75         00         25         NPI  | RENDERING                        |
| J.         J.           A.         DATE(S) OF SERVICE         B.         C.           From         To         YV         PLACE OF           M.         DD         YY         SERVICE         EMG           3         31         14         03         31         14         12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | In Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>POINTER<br>A  | S CHARGES         DA YS         IPMOT         ID.           S CHARGES         UNITS         Family         OUAL.         F           90         00         30         NP1         INP1  | RENDERING                        |
| J.         J.           A.         DATE(S) OF SERVICE         B.         C.           From         To         YV         PLACE OF           M         DD         YY         MM         DD         YY         EMG           3         31         14         03         31         14         12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | In Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>POINTER<br>A  | S CHARGES         DAYS         IPMOT         ID.         P           90         00         30         NPI         P           75         00         25         NPI  | RENDERING                        |
| J. L. DATE(S) OF SERVICE<br>From DD YY MM DD YY ENVICE EMG<br>3 3 1 14 03 31 14 12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | In Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>POINTER<br>A  | S CHARGES         DA YS<br>UNTS         Image<br>Page         ID.         P           90         00         30         NPI             75         00         25         NPI             NPI         NPI   | RENDERING                        |
| J. L. DATE(S) OF SERVICE<br>From DD YY MM DD YY ENVICE EMG<br>3 3 1 14 03 31 14 12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | In Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>POINTER<br>A  | S CHARGES         DAYS         Provide         ID.         P           90         00         30         NP1                NP1               NP1 <td>RENDERING</td>   | RENDERING                        |
| J. L. DATE(S) OF SERVICE<br>From To To YY ENCLOSE<br>M DD YY MM DD YY ENCLOSE<br>3 3 31 14 03 31 14 12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | In Unusual Circumstanc<br>S MODIFII   | es) DIAGNOSIS<br>POINTER<br>A  | S CHARGES         DA YS<br>UNTS         Image<br>Page         ID.         P           90         00         30         NPI             75         00         25         NPI             NPI         NPI   | RENDERING                        |
| J.     J.     B.     C.       M.     DO     YY     MM     DO     YY       J3     31     14     03     31     14     12       J4     02     14     02     14     12   | D.PROCED<br>(Expla<br>CPT/HCPC<br>S5125          | IN UNBURGENERAL COMMENCE<br>MODIFIE<br>UN<br>UN<br>UN<br>UN<br>SCOUNT NO. 27. | DIAGNOSIS           POINTER           I           A           I           A  | S CHARGES         DA YS<br>UNTS         Page<br>(Mar)         DA YS<br>(Mar)         Page<br>(Mar)         DA YS<br>(Mar)         Page<br>(Mar)         DA YS<br>(Mar)         Page<br>(Mar)         DA YS<br>(Mar)         Page<br>(Mar)         Page (Mar)         Page | RENDERING                        |
| J. L. DATE(S) OF SERVICE<br>From DD TY MM DD YY BRVICE EMG<br>3 31 14 03 31 14 12<br>4 02 14 04 02 14 12<br>1 1 1 1 1 1 12<br>1 1 1 1 1 1 12<br>1 1 1 1  | D.PROCED<br>(Expla<br>CP17HOPC<br>S5125<br>S5125 | IN UNBURGENE CIRCUMSTANCE<br>MODIFI   | DIAGNOSIS<br>POINTER           I         A           I         A           I         A           I         I     < | S CHARGES         DA YS<br>UNTS         Page<br>Page         DA YS<br>UNTS         Page<br>Page         DA YS<br>UND         Page         DA           90         00         30         NPI   | RENDERING<br>ROVIDER ID. #       |
| J.         J.<   | D.PROCED<br>(Expla<br>CP17HOPC<br>S5125<br>S5125 | IN UNBURGENERAL COMMENCE<br>MODIFIE<br>UN<br>UN<br>UN<br>UN<br>SCOUNT NO. 27. | DIAGNOSIS<br>POINTER           I         A           I         A           I         A           I         I     < | S CHARGES         DAYS         Provide         10.         P           90         00         30         NPI         P           75         00         25         NPI         P           75         00         25         NPI         P           28. TOTAL CHARGE         29. AMOUNT PAID         3         33. BLUNG PROVIDER NFO & PH#         (225) 55           Here For You Waiver         200 Main St.         200         P         1         1   | RENDERING<br>ROVIDER ID. #       |
| J.     J.     J.     B.     C.       4. A. DATE(S) OF SERVICE     True for the service of se | D.PROCED<br>(Expla<br>CP17HOPC<br>S5125<br>S5125 | IN UNBURGENE CIRCUMSTANCE<br>MODIFI   | DIAGNOSIS<br>POINTER           I         A           I         A           I         A           I         I     < | S CHARGES         DAYS         Processor         10.         P           90         00         30         NP1         75         00         25         NP1           75         00         25         NP1         10.   | RENDERING<br>ROVIDERID #         |

# CHAPTER 43: SUPPORTS WAIVER APPENDIX E – CLAIMS FILING

IN CONTRACT

**PAGE(S) 16** 

#### SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

|                  |            | TIONAL UN                                |                    |         |                |           | IUCC) 02/12                |                       |                 | Aľ        |                        |                                   |                  |                            |                       |             |                |               |                          |     |
|------------------|------------|--|--------------------|---------|----------------|-----------|----------------------------|-----------------------|-----------------|-----------|------------------------|-----------------------------------|------------------|----------------------------|-----------------------|-------------|----------------|---------------|--------------------------|-----|
|                  | PICA       |  |                    |         |                |           |                            |                       |                 |           |                        |                                   |                  |                            |                       |             |                |               | PICA                     | Ι   |
| MEDI             |            | MEDICA<br>(Medica                        |                    |         | CARE           |           | CHAMPV/<br>(Member l       |                       | GROUP<br>HEALTH | PLAN      | FECA<br>BLKL<br>(/D#)  | UNG (IDIII)                       |                  | RED'S I.D. N               |                       |             |                | (For Progra   | am in Item 1             | 1)  |
|                  |            | ME (Last Na                              |                    |         |                | Initial)  | (wentber i                 |                       |                 |           |                        | SEX                               |                  | 4321012<br>ED'S NAME       |                       | me. Firs    | t Name, Mid    | die initial)  |                          |     |
|                  | O, TR      |  |                    |         |                |           |                            | 07                    | 31              | 72        | M ×                    | F                                 |                  |                            |                       |             |                |               |                          |     |
| PATIEN           | NT'S AD    | DRESS (No                                | ., Street          | )       |                |           |                            |                       | ENT RE          | LATIONS   | SHIP TO I              | NSURED                            | 7. INSUR         | ED'S ADDR                  | ESS (No.              | Street)     |                |               |                          |     |
| TY               |            |  |                    |         |                |           | STATE                      | Self                  |                 | OUSE      | Child                  | Other                             | СПТҮ             |                            |                       |             |                |               | ISTATE                   |     |
|                  |            |  |                    |         |                |           | STATE                      | 0. RESE               | RVEDI           | ORNUC     | C USE                  |                                   |                  |                            |                       |             |                |               | SIATE                    |     |
| PCODE            | E          |  | TEI<br>(           | LEPHO   | NE (Indu       | de Area   | Code)                      | 1                     |                 |           |                        |                                   | ZIP COD          | E                          |                       | TEL         | EPHONE (Ir     | iclude Area   | (Code)                   |     |
| DTHEP            | RINSUR     | ED'SNAME                                 | (Last N            | lame, F | irst Name      | a, Middle | e Initial)                 | 10. IS I              | PATIEN          | T'S CONI  | DITION R               | ELATED TO:                        | 11. INSU         | RED'S POLI                 | CYGRO                 | JP OR F     | ECA NUME       | IER           |                          |     |
| OTHER            |            | ED'S POU C                               | YORG               | ROUP    | NUMBER         | R         |                            | a. EMP                |                 | NT? (Cun  | rent or Pr             | (intervious)                      | a. INSI          |                            | E OF BIR              | тн          |                | SEX           |                          |     |
| PL C             | ode it     | applical                                 | ble                |         |                |           |                            |                       |                 | YES       |                        | NO                                | 1                | M D0                       | 1 "                   |             | м              |               | F                        |     |
| ESEP             | RVED FO    | OR NUCCU                                 | SE                 |         | _              |           |                            | b. AUTO               |                 | DENT?     |                        | PLACE (State)                     | b. OTHE          | RCLAIMID                   | (Designat             | ed by N     | UCC)           |               |                          |     |
| ECEN             | NED 5      | R NUCC U                                 | SE .               |         |                | - X       | (AI                        | M                     | P               | YB        | • (                    | ツ┣━┘┃                             |                  | CERI                       |                       |             | GRAM NAM       | F             |                          |     |
| EGEN             | WEDPO      | A NOCC U                                 | 0E                 |         |                |           |                            |                       | E ACC           | YES       |                        |                                   |                  | NOL P                      |                       |             |                | -             |                          |     |
| SUR.             | ANCE P     | LAN NAME                                 | OR PR              | OGRAN   | NAME           |           |                            | 10d. RE               | SERVE           |           | OCAL US                | E                                 | d. IS THE        | RE ANOTH                   | ER HEAL               | TH BEN      | EFIT PLAN      | 7             |                          |     |
|                  |            |  |                    |         |                |           |                            |                       |                 |           |                        |                                   |                  | YES                        | NO                    | Ifyes, o    | complete iter  | ms 9, 9a an   | nd 9d.                   |     |
| ATIE             | INT'S OF   | R AUTHORIZ                               | ZED PE             | RSONS   | S SIGNAT       | TURE I    | OMPLETING<br>authorize the | release d             | of any m        | edical or | other info             | mation necessar                   | 13. INSU         | RED'S OR A<br>ent of medic | UTHORIZ<br>al benefit | ED PE       | RSON'S SIG     | NATURE I      | authorize<br>or supplier | for |
| o proc<br>selow. | cess this  | claim. I also                            | ne que st          | paymer  | t of gover     | mment     | enefits either!            | to myself             | ortothe         | party who | o a coepts             | assignment                        | servic           | es described               | i below.              |             |                |               |                          |     |
| SIGNE            | ED         |  |                    |         |                |           |                            |                       | DATE            |           |                        |                                   | SK               | INED                       |                       |             |                |               |                          |     |
| айте             | OFCUE      | RENTILLN                                 | ESS, IN            | JURY,   | or PREG        | NANCY     | (LMP) 15.0                 | OTHER D               | ATE.            | мм        | , DD                   | YY                                | 16. DATE         | S PATIENT                  |                       | TO WO       |                |               |                          |     |
|                  |            |  | QUAL               |         |                |           | QU                         |                       |                 |           |                        |                                   | FROM             |                            |                       |             | то             |               |                          |     |
| NAME             | OF RE      | FERRING P                                | ROVIDE             | ROR     | OTHER S        | JOURO     |                            | NPI                   |                 |           |                        |                                   | 18. HOSF         |                            | N DATES               | RELAT       | ED TO CUE<br>M | RENT SE       | RVICES                   |     |
| ADDIT            |            | OLAIM INFO                               | RMATI              | ON (De  | signated       | by NUC    |                            |                       |                 |           |                        |                                   |                  | IDE LAB?                   |                       |             | \$ CHARG       | ES            | <u>i</u>                 |     |
|                  |            |  |                    |         |                |           |                            |                       |                 |           |                        |                                   |                  | VES                        | NO                    |             |                |               |                          |     |
|                  |            | R NATURE                                 | OF ILLI            | NESSIC  | R INJUR        | Y R       | elate A-L to se            | arvice line           | beiow (         | 24E) K    | CD Ind. (              |                                   | 22. RESL<br>CODI | BMISSION                   |                       | ORI         | GINAL REF.     | NO.           |                          |     |
| G5               | 010        |  | в                  |         |                |           | C. L                       |                       |                 | -         | D.                     |                                   | 22.000           | R AUTHORI                  | ZATIONI               | JUNDE       |                |               |                          |     |
| L                |            |  | - F.               |         |                |           | G. L                       |                       |                 | -         | нL                     |                                   | Prior /          |                            |                       | TOHIDE      |                |               |                          |     |
| A.               | DATE       | (S) OF SERV                              | VICE               |         | B.<br>PLACE OF | C.        | D.PROCE                    | EDURES,<br>plain Unut | SERVI           | CES, OR   | SUPPLIE                | S E.<br>DIAGNOSIS                 |                  | F.                         | G.<br>DAYS            | H.<br>BPBDT | L              | DEA           | J.<br>NDERING            | _   |
| D                | rom<br>D Υ | ( MM                                     | DD                 | YY      | SERVICE        | EMG       | CPT/HCF                    | PCS                   | suar care       | MODIFI    | es)<br>ER              | POINTER                           | \$ CI            | ARGES                      | UNITS                 | Plan        | QUAL.          | PROV          | IDER ID. #               | ŧ   |
| 0                | 8 1        | 5 10                                     | 08                 | 15      | 12             |           | S512                       | 5                     | UN              |           |                        | A                                 | 1                | 90 00                      | 30                    |             | NPI            |               |                          |     |
| 0                | 9 1        | 5 10                                     | 09                 | 15      | 12             |           | S512                       | 5 1                   |                 |           |                        | A                                 |                  | 75 00                      | 25                    |             | NPI            |               |                          |     |
|                  |            |  |                    |         |                |           |                            | -                     |                 |           |                        |                                   | 1                |                            |                       |             |                |               |                          |     |
|                  |            |  |                    |         |                |           |                            |                       |                 |           |                        |                                   |                  |                            |                       |             | NPI            |               |                          |     |
|                  |            | 1 1                                      |                    |         |                |           |                            |                       |                 |           |                        |                                   | 1                |                            |                       |             | L N DI         |               |                          |     |
| 1                |            |  |                    |         |                |           | I                          |                       |                 | -         |                        |                                   | 1                | i                          | 1                     |             | NPI            |               |                          |     |
| 1                |            |  |                    |         |                |           | 1                          |                       | 1               | 1         |                        |                                   | 1                |                            | 1                     |             | NPI            |               |                          |     |
|                  |            |  |                    |         |                |           |                            |                       |                 |           |                        |                                   |                  |                            |                       |             |                |               |                          |     |
|                  |            |  |                    |         |                |           |                            |                       |                 |           |                        |                                   |                  |                            | <u> </u>              |             | NPI            |               |                          |     |
| FEDE             | RAL TA     | KI.D. NUMB                               | ER                 | S       | SN EIN         |           | PATIENT'S                  | ACCOUN                | IT NO.          | 27.       | ACCEPT<br>For govt. di | ASSIGNMENT?<br>ims,seeback)<br>NO |                  | AL CHARGE                  |                       |             | UNT PAID       |               | LANCE DU                 |     |
| SIGNA            |            | )F PHYSICI.                              | AN OP              | SUPPLI  | ER             |           | 234<br>SERVICE F/          | ACILITY               | OCAT            |           | YES<br>RMATION         |                                   | \$<br>33. BILI   | 165<br>ING PROVID          |                       | \$          | (225           | \$<br>) 555-4 |                          | 0   |
| NOLU<br>I certi  | JDING D    | EGREES OF<br>e statement<br>I and are ma | R CREE<br>s on the | ENTIA   | LS<br>e        |           | . Jan Contractor           |                       |                 |           |                        |                                   | HERE<br>200 N    | E FOR Y<br>MAIN ST         | ouw                   | AIVE        | ( ====         | , 555-4       | -307                     |     |
|                  | Inc.       | Siller                                   |                    |         | 10/12/         |           |                            |                       |                 |           |                        |                                   | _                | TOWN, I                    |                       | b.          | 10             | 39876         |                          | _   |
|                  | ima t      | Biller                                   |                    | DATE    | 10/15/         | 10 a.     |                            |                       | D.              |           |                        |                                   | a. 1             | 239676                     | 24                    | D.          | 12             | 39816         |                          |     |

### ADJUSTING/VOIDING CLAIMS

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

<u>Only a paid claim can be adjusted or voided</u>. 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.

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 43: SUPPORTS WAIVER APPENDIX E – CLAIMS FILING

# PAGE(S) 16

#### SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/01/15)

|   |                               |                      |                     |               |   | V                                |                    | 2 17                               | /F                   | ER                        |   |             |                      |                        |                |              |                              |    |
|---|-------------------------------|----------------------|---------------------|---------------|---|----------------------------------|--------------------|------------------------------------|----------------------|---------------------------|---|-------------|----------------------|------------------------|----------------|--------------|------------------------------|----|
|   |                               |                      |                     |               |   | -                                |                    |                                    |                      | _ • `                     |   |             |                      |                        |                |              |                              |    |
| PROVED BY NATIO   | NAL UNIFOR                    | MCLAIM               | соммп               | TTEE (N       | IUCC) 02/12                             |                                  |                    |                                    |                      |                           |   |             |                      |                        |                |              | PICA                         |    |
| MEDICARE  | MEDICAID                      | TRI                  | CARE                |               | CHAMPVA                                 | GROU<br>HEAL1                    | P                  | FEC                                |                      | OTHER                     | 1a. INSURED   | S I.D. NU   | MBER                 |                        |                | (For Progra  | am in Item 1)                | _  |
| (Medicare #) 🗙  |                               |                      | #/DoD#)             |               | (Member ID#                             | 9 (ID#)                          |                    | (ID#                               | 9                    | (ID#)                     | 98765432  |             |                      |                        |                |              |                              |    |
| PATIENT'S NAME  |                               | irst Nam             | e, Middle           | Initial)      | 2                                       |                                  |                    |                                    | SE                   | ^                         | 4. INSURED'S  | NAME (I     | .ast Nam             | e, First               | Name, Mid      | dle Initial) |                              |    |
| AYCO, TRAV<br>PATIENT'S ADDRE   |                               |                      |                     |               |   | 07 3<br>PATIENT F                | 1                  | 72 M                               |                      | F                         | 7. INSURED'S  | ADDRES      | SS (No. 1            | Street                 |                |              |                              |    |
| PATIENT S ADDRE   | :33 (NO., 314                 |                      |                     |               | · · · · · · · · · · · · · · · · · · ·   |                                  | Spouse             | Child                              |                      | ther                      | 7. INCOLLED C   | ADDITE      |                      | 00000                  |                |              |                              |    |
| тү  |                               |                      |                     |               | STATE 8                                 | RESERVE                          | D FOR I            | NUCC USE                           |                      |                           | СПҮ   |             |                      |                        |                |              | STATE                        |    |
| P.CODE  |                               |                      |                     |               |   |                                  |                    |                                    |                      |                           | ZIP CODE  |             |                      |                        |                |              |                              |    |
| CODE  | 1                             | -                    | NE (Inclu           | de Area       | Code)                                   |                                  |                    |                                    |                      |                           | ZIP CODE  |             |                      | TELE                   | PHONE (Ir      | idude Area   | a Code)                      |    |
| OTHER INSURED   | S NAME (Las                   | (                    | )<br>First Name     | . Middle      | e Initial)                              | 10. IS PATIE                     | NTSC               | ONDITION                           | RELAT                | FD TO:                    | 11. INSURED   | S POLIC     | ( GROUI              | PORF                   |                | ER           |                              |    |
|   |                               |                      |                     | o, neo an     | ,                                       |                                  |                    | Chipmon                            |                      |                           |   |             |                      |                        |                |              |                              |    |
| OTHER INSURED'  | S POLICY OF                   | RGROUP               | NUMBER              | R             | a                                       | . EMPLOYM                        | IENT? (            | Current or                         | Previou              | 9                         | a. INSURED  |             | OF BIRT              | н                      |                | SEX          |                              |    |
| PL Code if ap   |                               |                      |                     |               |   |                                  | YE                 | S                                  | NO                   |                           |   |             |                      |                        | м              |              | F                            |    |
| RESERVED FOR N  | OUU USE                       |                      |                     |               | 1 C                                     | AUTO ACC                         |                    | ілг                                |                      | ACE (State)               | b. OTHER CLA  | um ID (D    | esignated            | a by NU                | ICC)           |              |                              |    |
| RESERVED FOR N  | UCC USE                       |                      |                     |               |   |                                  | CIDEN              | yı F                               |                      |                           | c. INSURANCE  | EPLANI      |                      | RPROG                  | RAM NAM        | E            |                              |    |
|   |                               |                      |                     |               | ľ                                       |                                  | YE                 | S                                  | NO                   |                           |   |             |                      |                        |                |              |                              |    |
| NSURANCE PLAN   | NAME OR P                     | ROGRAM               | INAME               |               |   | RESERV                           | ED FO              | PLOCAL                             | Õ                    | - 16                      | I I OTHERE  | NOTHER      | RHEALT               | H BENE                 | EFIT PLAN      | ?            |                              | -  |
|   |                               |                      |                     |               |   |                                  | <b>~</b> L         |                                    |                      | - 10                      | YES   |             |                      | -                      | omplete iter   |              |                              |    |
| PATIENT'S OR AU<br>to process this clain<br>below.                                    | THORIZED F<br>n. I also reque | ERSON'S              | S SIGNAT            | FURE I        | authorize the re<br>enefits either to r | lease of any<br>myself or to the | medica<br>he party | KM.<br>I or other in<br>who accept | formations to assign | in necessary<br>iment     | 13. INSURED'S<br>payment of<br>services de  | medical     | benefits t           | to the u               | ndersigned     | physician    | or supplier fo               | r  |
| SIGNED  |                               |                      |                     |               |   | DAT                              | Е                  |                                    |                      |                           | SIGNED  |             |                      |                        |                |              |                              |    |
| DATE OF CURREI  | YT ILLNESS,<br>QU             |                      | or PREG             | NANCY         | (LMP) 15.OT                             | HER DATE                         | N                  |                                    | 1 22                 |                           | 16. DATES PA<br>MN<br>FROM  |             | NABLE T              | O WOF                  | TO RK IN CURI  |              | VPATION<br>YY                |    |
| NAME OF REFER   | RING PROVI                    | DEROR                | OTHER S             | OURCE         | Tra.                                    |                                  |                    |                                    |                      |                           | 18. HOSPITALI<br>MM<br>FROM   |             | DATES                | RELATE                 | ED TO CUP<br>M | RENT SE      | RVICES                       | _  |
| ADDITIONAL CLA  |                               | TION (De             | esign ated          | by NUC        |   |                                  |                    |                                    |                      |                           | 20. OUTSIDE I   |             | <u>i</u><br>         |                        | \$ CHARGE      | ES           | i                            |    |
| DIAGNOSIS OR N  | ATURE OF IL                   | LNESS C              | OR INJUR            | Y R           | elate A-L to servi                      | ice line below                   | (24E)              | ICD Ind.                           | 9                    |                           | YES<br>22. RESUBMIS   |             | 10                   | ORIC                   | INAL REF.      | NO           |                              |    |
| 3510  |                               | в. [                 |                     |               | C. ]                                    |                                  |                    | D.                                 | 1                    |                           | A 00  |             | 4                    |                        | 987654         |              |                              |    |
| 1   |                               | F.                   |                     |               | G.                                      |                                  |                    | H.                                 |                      |                           | 23. PRIOR AU  |             | ATION N              | UMBER                  |                |              |                              |    |
| A. DATE(S) (  | _                             | J. L                 | В.                  | C.            | к. 🔄                                    |                                  |                    | L.                                 | L                    |                           | 41231231  | 23          |                      |                        |                |              |                              |    |
| From<br>DD YY   | DF SERVICE<br>To<br>MM DD     | **                   | PLACE OF<br>SERVICE | EMG           | (Explain<br>CPT/HCPC:                   | URES, SERV<br>in Unusual C<br>S  | ircumst            | ances)<br>DIFIER                   | IES I                | POINTER                   | s CHARG   | ES          | DA YS<br>OR<br>UNITS | PSOT<br>Family<br>Plan | ID.<br>QUAL.   | REM<br>PROV  | J.<br>IDERING<br>/IDER ID. # |    |
| 31 14   | 03 31                         | 14                   | 12                  |               | S5125                                   | UN                               |                    | 1 1                                |                      | А                         | 75  | 00          | 25                   |                        | NPI            |              |                              |    |
|   |                               |                      |                     |               |   |                                  | 1                  | 1 1                                |                      |                           |   |             |                      | 1 1                    | NPI            |              |                              |    |
|   |                               |                      |                     |               |   |                                  |                    |                                    |                      |                           |   |             |                      |                        |                |              |                              |    |
|   |                               |                      |                     |               |   |                                  |                    |                                    |                      |                           |   |             |                      |                        | NPI            |              |                              | _  |
| 1 1   | 1                             |                      | 1                   |               |   |                                  | 1                  | 1 1                                | 1                    |                           |   | 1 1         |                      | 1 0                    | NPI            |              |                              | _  |
| 1   | i                             | 1                    | 1                   |               | 1                                       |                                  | 1                  | <u> </u>                           |                      |                           |   | 1           |                      |                        | and 1          |              |                              |    |
|   |                               |                      |                     |               |   |                                  |                    | 1 1                                |                      |                           |   |             |                      | [                      | NPI            |              |                              |    |
|   |                               |                      |                     |               |   |                                  |                    |                                    |                      |                           |   |             |                      |                        |                |              |                              |    |
|   |                               |                      |                     |               |   |                                  | Ι.,                |                                    |                      |                           |   |             |                      |                        | NPI            |              |                              | _  |
| FEDERAL TAXI.D  | . NUMBER                      | S                    | SN EIN              | 26            | . PATIENT'S AC                          | COUNT NO.                        |                    | 27. ACCEP<br>(For govt.<br>X YES   | claims, a            | SNMENT?<br>se back)<br>NO | 28. TOTAL CI  | 1ARGE       |                      |                        | UNT PAID       | 30. BA       | LANCE DUE                    | ÷. |
| SIGNA TURE OF P<br>INCLUDING DEGF<br>(I certify that the st<br>apply to this bill and | REES OR CR<br>atements on t   | EDENTIA<br>he revers | LS<br>0             | 32            | SERVICE FAC                             | ILITY LOCA                       |                    |                                    |                      |                           | <ul> <li>BILLING F</li> <li>Here For</li> <li>200 Main</li> <li>Any Towr</li> </ul> | You V<br>St | R INFO               | & PH #                 | ( 225          | ) 555-4      | 957                          |    |
| <sub>GNED</sub> Jane Do   | )e                            | DATE                 | 4/9/1               | 4 -           |   | Þ                                |                    |                                    |                      |                           |   | 37654       |                      | <b>)</b> .             | 12             | 39876        |                              |    |
|   | ~~                            | DATE                 |                     | - <b>r</b> a. |   | D.                               |                    |                                    |                      |                           |   |             | OMB-0                |                        |                | 00010        |                              |    |

PAGE(S) 16

#### SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

| PROVED BY NATION  | IRANCE   |            |                           |                                 | UCC) 02/12  | vv   | ΑΙ               | VEI                           | R  |  |  |  |  |   |                       | PICA                           |
|---|--|------------|---------------------------|---------------------------------|---|--|------------------|-------------------------------|--|--|--|--|--|---|-----------------------|--------------------------------|
| MEDICARE M  | IEDICAI D  | TR         | CARE                      |                                 | CHAMPVA   | GROUP  | ,<br>H PLAN      | FECA<br>BLK LUNK              | OTHER  | 1a. INSURED'S  | S I.D. NUM   | MBER   |  |   | (For Prog             | ram in Item 1)                 |
| (Medicare#) X (M  |  |            | MDoD#)                    |                                 | (Member ID#)  | (D#)<br>PATIENTS<br>MM D                     |                  |                               | 9 (IDIII)<br>SEX   | 98765432   |  |  |  |   |                       |                                |
| PATIENT'S NAME (L<br>AYCO, TRAVI  |  | rst Nami   | e, Middle                 | Initial)                        | 3.  | 07 3   |                  | MX MX                         | -  | 4. INSURED'S   | NAME (L  | astNam   | e, First N   | lame, Mi  | ddle Initial)         |                                |
| PATIENT'S ADDRES  |  | ()         |                           |                                 | 6.  |  |                  | SHIP TO INSU                  | JRED   | 7. INSURED'S   | ADDRES   | S (No., 8  | Street)  |   |                       |                                |
|   |  |            |                           |                                 |   | Self Sp                                      | pouse            | Child                         | Other  |  |  |  |  |   |                       |                                |
| TY  |  |            |                           |                                 | STATE 8.  | RESERVED                                     | FOR NUC          | X USE                         |  | CITY   |  |  |  |   |                       | STATE                          |
| PCODE   | TE   | LEPHO      | NE (Indu                  | ide Area                        | Code)   |  |                  |                               |  | ZIP CODE   |  |  | TELEP  | HONE (  | include Are           | a Code)                        |
|   |  |            | )                         |                                 |   |  |                  |                               |  |  |  |  | (  | )   |                       |                                |
| OTHER INSURED'S   | NAME (Last   | Name, F    | irst Name                 | e, Middle                       | Initial) 1  | 0. IS PATIEN                                 | IT'S CONE        | DITION RELA                   | TED TO:  | 11. INSURED'S  | S POLICY   | GROUP  | OR FE  | CANUM   | BER                   |                                |
| OTHER INSURED'S   | POLICY OR  | GROUP      | NIMBE                     | P                               |   | END OWNE                                     | NT2/Crm          | rent or Previo                |  | a INSURED  | SDATE  |  | н  |   | SEX                   |                                |
| PL Code if ap   |  | GROOP      | NONIDE                    |                                 | a.  | EMPLOTINE                                    | YES              | NO                            | us)  | a. INSURED<br>MM   | 00   | YY   |  | м   |                       | F                              |
| RESERVED FOR NU   |  |            |                           |                                 | b.  |  |                  | F                             | LACE (State)   | b. OTHER CLA   | MID (De  | esignated  | d by NUC   | 00)   |                       |                                |
|   |  |            |                           |                                 |   | SΛ   |                  |                               |  |  |  |  |  |   |                       |                                |
| ESERVED FOR NU  | JCC USE  |            |                           |                                 | G.  | <b>1 / //</b>                                | IC N             |                               |  | c. INSURANCE   | E PLAN N   | AME OF   | R PROGE  | RAM NAM   | ME                    |                                |
| NSURANCE PLAN 1   | NAME OR PR   | OGRAN      | INAME                     |                                 | 10  | d. RESERV                                    | YES<br>ED FOR LO | OCAL USE                      |  | d. IS THERE A  | NOTHER   | HEALT  | H BENER  | FIT PLAN  | <i>n</i>              |                                |
|   |  |            |                           |                                 |   |  |                  | - 0                           |  |  |  |  |  |   | <br>am s 9, 9a a      | and 9d.                        |
| PATIENT'S OR AUT  | READ BA  |            |                           | FOR                             | WANA  | G IN TH                                      | IS FOF L         |                               |  | 3. INC JRF /S  | Medicart   | O ZE   | D PERS   | ON'S SK   | GNATURE               | I authorize<br>or supplier for |
| o process this claim.   | I also reques  | t paymer   | nt of gove                | mmentb                          | enefits either to m   | sase on any in<br>tyself or to the           | e party who      | o a coepts assi               | gnment   | services de  | sofbed be  | elow.  | o me un  | densigner   | a priysician          | or supplier for                |
| SIGNED  |  |            |                           |                                 |   | DATE   |                  |                               |  | SIGNED   |  |  |  |   |                       |                                |
|   | TILLNESS, I  | NJURY,     | or PREG                   | NANCY                           | (LMP) 15.OTH  | IER DATE                                     | мм               | DD . )                        | CY.  | 16. DATES PAT  | TIENT UN   | ABLE T   | O WOR  |   | RENT OC               | CUPATION                       |
|   | QUA  | L          |                           |                                 | QUAL.   |  |                  |                               |  | FROM   | 00   | 1 1  |  | то  |                       | · · · ·                        |
| NAME OF REFERR  | ING PROVID   | ER OR I    | OTHER 8                   | SOURCE                          | 17a.  |  |                  |                               |  |  |  |  |  |   |                       |                                |
|   |  |            |                           |                                 |   | ~  |                  |                               |  | 18. HOSPITALI  | ZATION   | DATES  | RELATE   |   | RRENT SE              | RVICES                         |
|   |  |            | wice stad                 | by NUC                          | 71b. N  | PI   |                  |                               |  | FROM   |  | DATĘŞI   |  | то  |                       | RVIQES                         |
|   |  | ION (De    | signated                  | by NUC                          | 71b. N  | PI   |                  |                               |  | FROM<br>20. OUTSIDE L  | AB?  | <u> </u>   |  |   |                       | PRVIQES                        |
| ADDITIONAL CLAIM  | INFORMAT   |            |                           |                                 | 71b. N  |  | (24E) K          | CD Ind. 0                     |  | FROM<br>20. OUTSIDE L  | AB?<br>N   | io   | ORIGI  | TO<br>CHARG   | RES                   | RVICĘŞ                         |
| ADDITIONAL CLAIM<br>DIAGNOSIS OR NA   |  | NESS (     |                           |                                 | 71b. N<br>C)<br>Rate A-L to servic<br>C.  |  | (24E) K          | D.                            |  | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE   | AB?<br>N<br>SION<br>A02  | · · · · · · · · · · · · · · · · · · ·  | ORIGI<br>52991   | TO<br>CHARG   | RES                   | RVIQES                         |
| ADDITIONAL CLAIM<br>DIAGNOSIS OR NA   |  | NESS       |                           |                                 | 71b. N<br>C)<br>late A-L to servic<br>C<br>G  |  | (24E) K          |                               |  | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AU   | AB?<br>N<br>SION<br>A02<br>THORIZA   | · · · · · · · · · · · · · · · · · · ·  | ORIGI<br>52991   | TO<br>CHARG   | RES                   | RVIQES                         |
| ADDITIONAL CLAM<br>DIAGNOSIS OR NA<br>1 <b>G5 10</b><br>L<br>A. DATE(S) OF  | TURE OF ILL  | NESS (     | DR INJUR                  |                                 | 71b. N<br>C)<br>Kate A-L to servic<br>C<br>G<br>K<br>D.PROCEDU  | e line below                                 |                  |                               | E  | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | 10<br>2 1  | ORIGI<br>52991<br>UMBER  | TO<br>CHARG   | BES<br>NO.<br>18700   |                                |
| ADDITIONAL CLAIM<br>DIAGNOSIS OR NA<br>1 G5 10<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1  | INFORMAT   | NESS (     | OR INJUR                  | RY Re                           | 71b. N<br>C)<br>Kate A-L to servic<br>C<br>G<br>K<br>D.PROCEDU  | e line below                                 |                  |                               | E<br>DIAGNOSIS<br>POINTER  | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AU   | AB?<br>N<br>SION<br>A02<br>THORIZA   | · · · · · · · · · · · · · · · · · · ·  | ORIGI<br>52991<br>UMBER  | TO<br>CHARG   | SES<br>E NO.<br>18700 | J.<br>NDERING<br>MDER ID. #    |
| ADDITIONAL OLAM<br>DAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>From L<br>DD YY  | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | ORIGI<br>52991<br>JMBER<br>H.<br>Branty<br>Plan  | L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAM<br>DAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>From<br>I DD YY  | M INFORMAT   | .NESS (    | B.<br>PLACE OF            | RY Re                           | 71b. N<br>C)<br>C)<br>C<br>G<br>K<br>PROCEDU<br>(Feolair  | e line below                                 | ICES, OR         |                               | DIAGNOSIS  | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | 10<br>2 1  | ORIGI<br>52991<br>JMBER<br>H.<br>Branty<br>Plan  | TO<br>CHARG   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAM<br>DAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>From<br>I DD YY  | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | ORIGI<br>52991<br>UMBER<br>H.<br>Braty<br>Plan   | L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L<br>L   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAM<br>JAGNOSIS OR NA<br>J <mark>G5 10</mark><br>L<br>A. DATE(S) OF<br>From DD YY   | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | S<br>ORIGII<br>52991<br>UMBER<br>H<br>Heroty<br>Plan   |   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAM<br>DAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>From<br>I DD YY  | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | S<br>ORIGII<br>52991<br>UMBER<br>H<br>Heroty<br>Plan   | L<br>ID<br>NAL REF<br>19879   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAM<br>DAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>From L<br>DD YY  | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | ORIGII<br>52991<br>JMBER<br>H.<br>Farity<br>Film   |   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAIM<br>DIAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>1 DD YY  | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | S<br>ORIGI<br>52991<br>JMBER<br>HUT<br>Factor<br>Factor<br>Factor  | TO<br>CHARG<br>NAL REP<br>19879   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL OLAIM<br>DIAGNOSIS OR NA<br>1 G5 10<br>L<br>L<br>A. DATE(S) OR<br>1 DD YY  | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   | S<br>ORIGI<br>52991<br>JMBER<br>HUT<br>Factor<br>Factor<br>Factor  | TO<br>I CHARG<br>NAL REF<br>19879<br>10<br>304L<br>NPI  | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL CLAIM<br>DAGNOSIS OR NA<br>1 G5 10<br>1<br>1<br>1<br>4. DATE(S) OR<br>4. DATE(S) OR<br>4. DATE(S) OR<br>5. DATE(S) OR | TURE OF ILL<br>F SERVICE<br>MM DD                        |            | B.<br>PLACE OF<br>SERVICE | RY Re                           | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below<br>IRES, SERVI<br>I Unusual Cir | ICES, OR         |                               | DIAGNOSIS<br>POINTER   | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB?<br>N<br>SION<br>A02<br>THORIZA   | C IO   |  | L<br>BAL REF<br>L9879   | SES<br>E NO.<br>18700 | J.<br>NDERING                  |
| ADDITIONAL CLAIM<br>DAGNOSIS OR NA<br>1 G5 10<br>1<br>1<br>1<br>4<br>DATE(S) OF<br>4<br>DD YY   | A INFORMAT<br>TURE OF ILL<br>SERVICE<br>MM DD<br>10 08   | NESS (<br> | B.<br>PLACE OF<br>SERVICE | C.<br>EMG                       | 71b. N<br>C)<br>C<br>G<br>C<br>G<br>D.PROCEDU<br>(Explain<br>CPT/HCPCS  | e line below                                 |                  |                               | A Contraction of the second se | FROM<br>20. OUTSIDE L<br>YES<br>22. RESUBMIS<br>CODE<br>23. PRIOR AUT<br>Prior Auth<br>F.<br>\$ CHARGE   | AB7 N<br>SSION A02<br>THORIZA<br>#<br>000  <br>  |  |  | TO<br>CHARG<br>NAL REP<br>19879   | RE PRO                | J.<br>NDERING                  |
| ADDITIONAL C. AM<br>IGS 10<br><br>A. DATE(S) OI<br>A DOT YY<br>0 08 15  <br><br><br><br><br><br><br>  | A INFORMAT<br>TURE OF ILL<br>SERVICE<br>MM DD<br>10 08   | NESS (<br> | B<br>PLACE OF<br>SERVICE  | TY Re                           | 71b N     7   | e line below                                 |                  |                               | A Contraction of the second se | FROM 20. OUTSIDE L YES 22. RESUBMIS 22. PRIOR AUT Prior Auth F. \$ CHARGE 90   | AB7 N<br>SSION A02<br>THORIZA<br>#<br>000  <br>  | 0<br>2<br>1<br>100 NU<br>2<br>100 NU<br>200<br>30  |  | NPI   | RE PRO                | J.<br>NDERING<br>VIDER ID. #   |
| ADDITIONAL CLAM ADDITIONAL CLAM G5 10  A. DATE(S) OI From DD YY D 08 15   | A INFORMAT<br>TURE OF ILL<br>F SERVICE<br>MM DD<br>10 08 | NESS (     |                           | TY Re<br>C.<br>EMG<br>20.<br>12 | 71b N 77b N   | IRES, SERVICE<br>Unusual Cr<br>UN            | ICES, OR OWNER   | D L. L. SUPPLIES BI)<br>BI ER | A CONTER  | FROM 20. OUTSIDE L YES 22. RESUBMIS 22. RESUBMIS 22. RESUBMIS 23. PRIOR AU Prior Auth F. \$ CHARGE 90 28. TOTAL CF 3 33. BILLING F 33. BILLING F | AB?<br>N<br>SION<br>AO:<br>THORIZA<br>#<br>ES<br>00  <br>4<br>AB?<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N   | 2 11<br>TTION NI<br>0<br>0<br>30<br>2<br>1<br>30<br>2<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1 | 8<br>ORIGII<br>5299<br>JMBR<br>Path<br>Path<br>Path<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C | TO<br>CHARGE<br>NAL REF<br>100<br>NAL REF | RE<br>PRO<br>30. B    | NDERING<br>VICER ID. #         |
| ADDITIONAL CLAM ADDITIONAL CLAM G5 10  A. DATE(S) OI From YY 0 08 15  | A INFORMAT<br>TURE OF ILL<br>F SERVICE<br>MM DD<br>10 08 | NESS (     |                           | TY Re<br>C.<br>EMG<br>20.<br>12 | 71b N<br>17b N<br>1 | IRES, SERVICE<br>Unusual Cr<br>UN            | ICES, OR OWNER   | D L. L. SUPPLIES BI)<br>BI ER | A CONTER  | FROM 20. OUTSIDE L YES 22. PRIOR AU Prior Auth F. \$ CHARGI 90 28. TOTAL OF 3 33. BILLING F  | A87<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N   | 2 11<br>TTION NI<br>0<br>0<br>30<br>2<br>1<br>30<br>2<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1<br>1 | 8<br>ORIGII<br>5299<br>JMBR<br>Path<br>Path<br>Path<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C<br>C | TO<br>CHARGE<br>NAL REF<br>100<br>NAL REF | SES                   | NDERING<br>VICER ID. #         |
| ADDITIONAL C. AM<br>IGS 10<br><br>A. DATE(S) OI<br>A DOT YY<br>0 08 15  <br><br><br><br><br><br><br>  | A INFORMAT<br>TURE OF ILL<br>F SERVICE<br>MM DD<br>10 08 | NESS (     |                           | TY Re<br>C.<br>EMG<br>20.<br>12 | 71b N<br>17b N<br>1 | IRES, SERVICE<br>Unusual Cr<br>UN            | ICES, OR OWNER   | D L. L. SUPPLIES BI)<br>BI ER | A CONTER  | FROM 20. OUTSIDE L YES 22. RESUBMIS 22. RESUBMIS 22. RESUBMIS 23. PRIOR AU Prior Auth F. \$ CHARGE 90 28. TOTAL CF 3 33. BILLING F 33. BILLING F | A87<br>NA87<br>A020<br>SIGN<br>#<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant<br>Constant |  | SCHORE STATES  | TO<br>CHARGE<br>NAL REF<br>100<br>NAL REF | SES                   | NDERING<br>VICER ID. #         |

| PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA MEDICARE MEDICAID TRICARE CHAMPI  |   |  |   |
|--|---|--|---|
| . MEDICARE MEDICAID TRICARE CHAMP  |   |  | PICA  |
|  |   | a 1a. INSURED'S I.D. NUMBER  | (For Program in litem 1)  |
| (Medicare#) (Medicaid#) (ID#/DoD#) (Member<br>2 PATIENT'S NAME (Lest Name, First Name, Middle Initial)   | (ID#)         (ID#)         (ID#)           3. PATIENT'S BIRTH DATE         SEX           MM         DD         YY  | 4. INSURED'S NAME (Last Name, F  | Trat Name, Middle Initial)  |
|  | MM DD YY M F  | 1  |   |
| 5. PATIENT'S ADDRESS (No., Street)   | 6. PATIENT RELATIONSHIP TO INSURED<br>Self Spouse Child Other   | 7. INSURED'S ADDRESS (No., Stre  | ei)   |
| CITY STATE   |   | CITY   | STATE   |
|  |   |  |   |
| ZIP CODE TELEPHONE (Include Area Code)   |   | ZIP CODE T   | ELEPHONE (Include Area Code)  |
| 8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  | 10. IS PATIENT'S CONDITION RELATED TO:  | 11. INSURED'S POLICY GROUP O   | R FECA NUMBER   |
|  |   |  |   |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER  | a. EMPLOYMENT? (Current or Previous)  | a. INSURED'S DATE OF BIRTH   | MF  |
| RESERVED FOR NUCC USE  | b. AUTO ACCIDENT? PLACE (State)   | b. OTHER CLAIM ID (Designated by   |   |
|  |   |  |   |
| RESERVED FOR NUCC USE  | C. OTHER ACCIDENT?  | C. INSURANCE PLAN NAME OF PR   | ROGRAM NAME   |
| LINSURANCE PLAN NAME OR PROGRAM NAME   | 10d. CLAIM CODES (Designated by NUCC)   | d. IS THERE ANOTHER HEALTH B   | ENEFIT PLAN?  |
|  |   |  | es, complete items 9, 9a, and 9d.   |
| READ BACK OF FORM BEFORE COMPLETIN<br>2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 suborts the<br>to process this claim. I also request payment of government benefits eithe  | Is a standard THIS FORM.<br>release of any medical or other information necessary<br>to medical or to the party with accessing and present  | <ol> <li>INSURED'S OR AUTHORIZED F<br/>payment of medical benefits to the<br/>services described below.</li> </ol> | ERSON'S SIGNATURE I authorize<br>e undersigned physician or supplier for  |
| below.   | and the second |  |   |
| SIGNED   | DATE  | SIGNED   |   |
|  | AL DD YY  | 16. DATES PATIENT UNABLE TO V<br>MM DD YY<br>FROM  | TO  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17  |   | 18. HOSPITALIZATION DATES REL<br>MM DD DATES REL   | ATED TO CURRENT SERVICES  |
| 9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)   | b. NPI  | FROM<br>20. OUTSIDE LAB?   | TO<br>\$ CHARGES  |
| and (magnet of 1000)   |   |  |   |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to ser   | vice line below (24E) ICD ind.  | 22. RESUBMISSION   | RIGINAL REF. NO.  |
| A B C. I   | D   | 23. PRIOR AUTHORIZATION NUMI   |   |
|  | H   |  |   |
|  | EDURES, SERVICES, OR SUPPLIES E.<br>Iain Unusual Circumstances) DIAGNOSIS   | F. G. DAYS EP<br>S CHARGES UNITS P   | L L J.<br>DT ID. RENDERING<br>May CLAL PROVIDER ID. #                     |
| From To PLACEOF (Expl  |   | \$ CHARGES UNITS P   | QUAL PROVIDER ID. #   |
| From To PLACEOF (Expl  |   |  |   |
| From To PLACE OF (Expl   |   |  | NPI   |
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| From To PLACE OF (Expl   |   |  | NPI   |
| From To PLACE OF (Expl   |   |  | NPI   |
| From To PLACEOF (Expl  |   |  | NPI           NPI           NPI           NPI           NPI           NPI |
| Place of Pla |   | 28. TOTAL CHARGE 29. AJ  | NPI<br>NPI<br>NPI   |
| From<br>DD     YY     MM     DD     YY     SERVE     EMG     (Eppinder)       1     1     1     1     1     1     1     1       1     1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1     1     1     1     1       1     1     1  | YES NO  | \$ S   | NPI                                   |
| Prom       To       PLACEOF       EMG       (Epp)         DD       YY       MM       DD       YY       SERMOE       EMG       CPT/HCI         I       I       I       I       I       I       I       I       I         I       I       I       I       I       I       I       I       I       I       I         I  |   | A REPORT OF A REPORT OF A REPORT   | NPI                                   |
| Priom     To     PL/LECF     EMG     (Epp)       DD     YY     MM     DD     YY     SERVE     EMG     CPT/HCI       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       C     C     C     C     C     C     C     C       S     C     C     C     C     C     C     C       C  | YES NO  | \$ S   | NPI                                   |