

Claim Form Completion Requirements

Jefferson Health Plans

Claim Form Completion Requirements

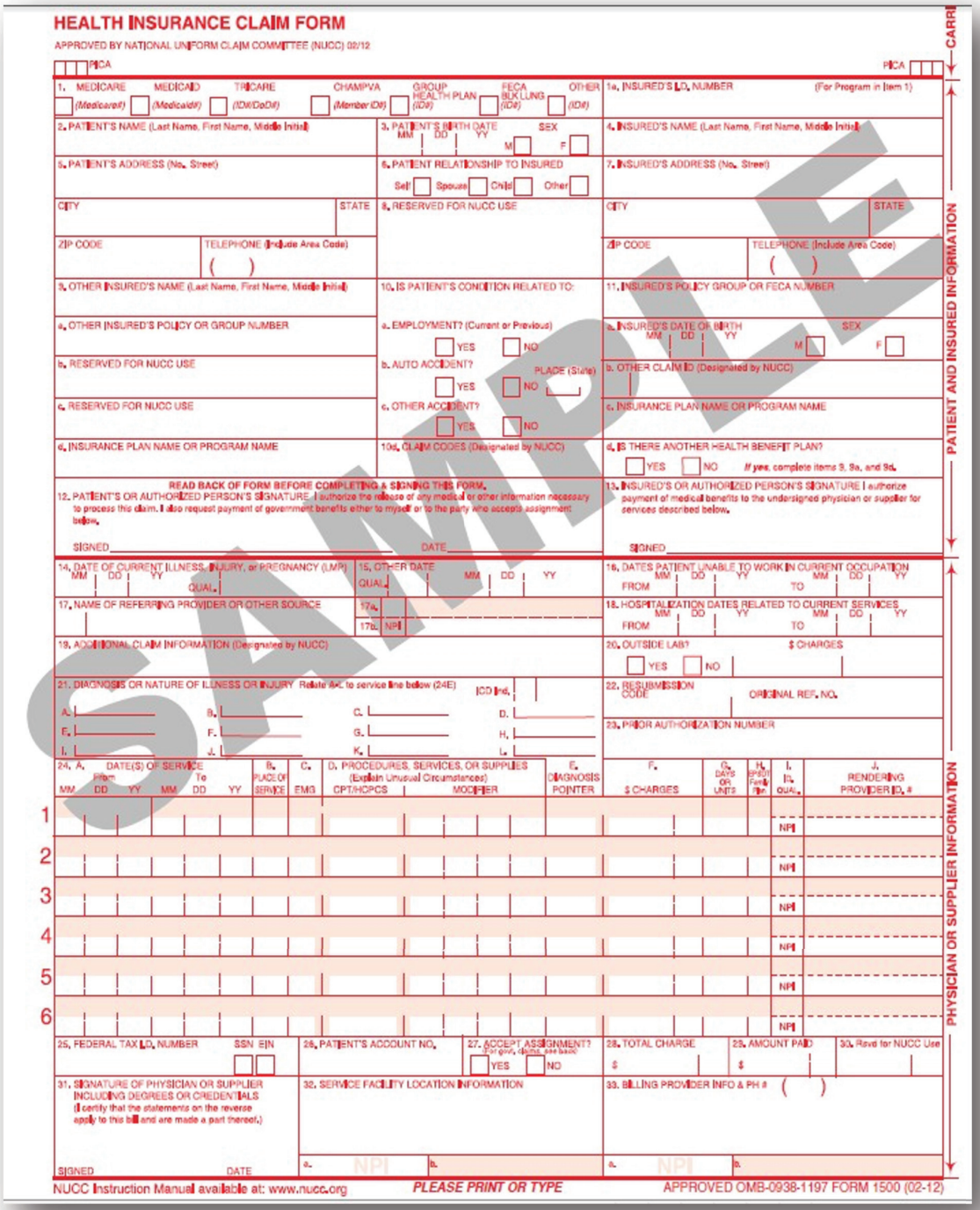
Claim form completion requirements for both CMS-1500 and UB-04 forms are displayed below. Each field is listed by number and includes a description of the data needed along with an "R", "C" or "O" field code.

"R" (required). If the field is coded "R" (required), the data must be completed on every form submitted. If the field is not complete or contains invalid data, the claim will not be considered for payment.

"C" (conditional). If a field is coded "C" (conditional), the data is required only for claims submissions where the field is directly related to the billed services for that record type. However, if the information is not included but is applicable to the billed services, the claim will not be considered for payment. Only claims completed as outlined will be eligible for payment consideration.

"O" (optional). A field coded "O" is optional.

Sample CMS-1500 Form (Version 8-05 New Form)



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRI

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

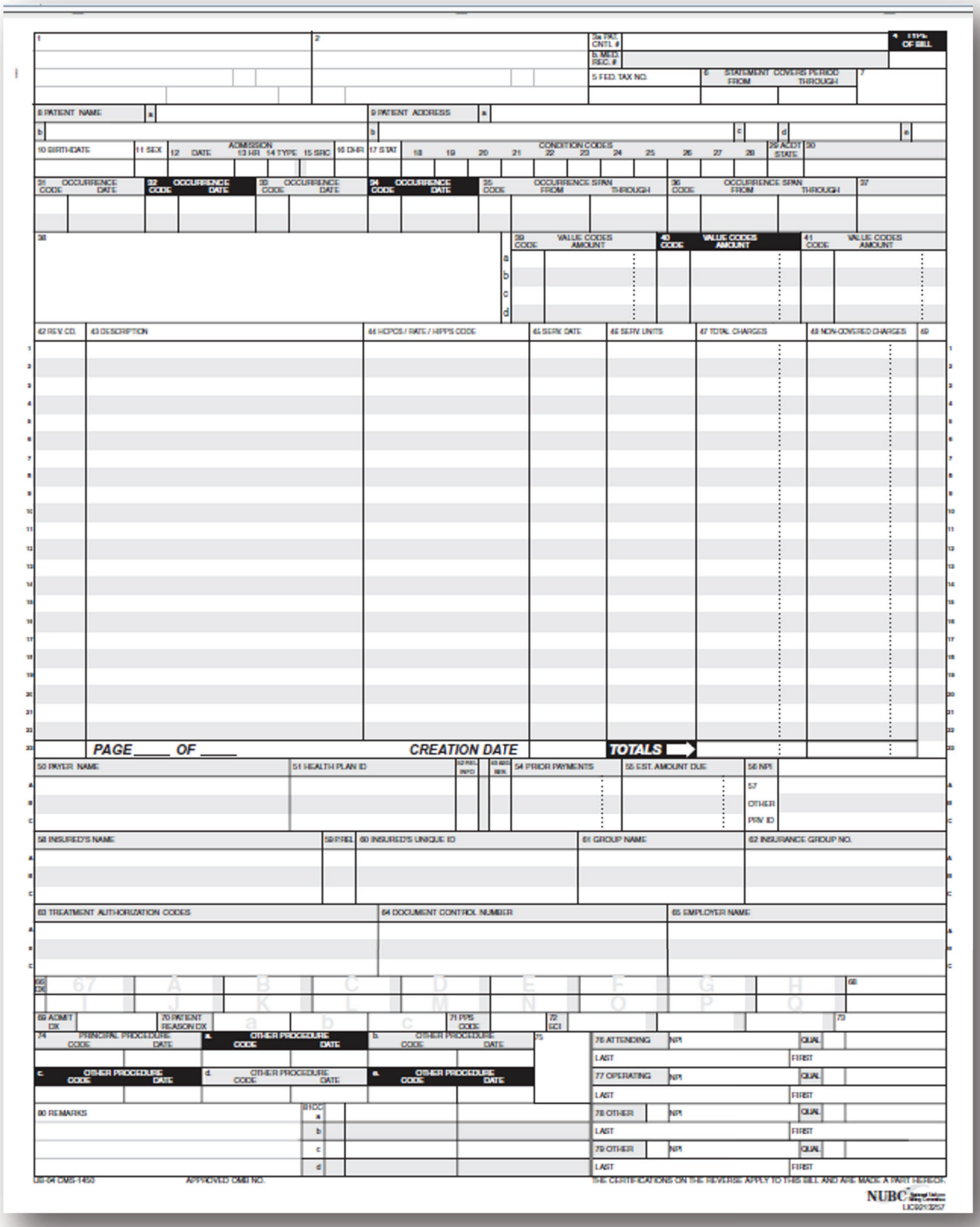
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Billing Requirements for CMS-1500 Form (Version 8-05 New Form)		
Field	**Field Description**	**R (Required) C (Conditional) O (Optional)**
1a	Jefferson Health Plans ID number	R
2	Patient name (last name, first name, middle initial)	R
3	Patient's birth date and sex	R
4	N/A (Same as field #2)	R
5	Patient complete address and telephone number	R
6	Patient's relationship to insured	R
7	N/A (Same as field #5)	C
8	Patient's status	C
9	Other insured information	C
10	Is patient condition related to: a. Employment? b. Auto accident? c. Other accident?	 R R R
11	Insured's policy group or FECA number	C
11a	Insured's date of birth	C
11b	Employer's name or school name	C
11c	Insurance plan or program name	C
11d	Is there another health benefit plan?	R
12	Patient's or authorized person's signature	R
13	Insured's or authorized person's signature	C
14	Date of current illness, injury, pregnancy	C
15	Date of same or similar illness	C

Billing Requirements for CMS-1500 Form (Version 8-05 New Form)		
Field	**Field Description**	**R (Required) C (Conditional) O (Optional)**
16	Dates patient unable to work in current occupation	C
17	Name of referring physician	C
17a	Other referring ID number (must be reported with one of the NUCC qualifiers)	C
17b	NPI (the referring HIPAA NPI number)	C
18	Hospitalization dates related to current services	C
19	Medical License Number	R
20	Outside lab?	C
21	Diagnosis code(s) relate items to 24c by procedure line	R
22	Medicaid resubmission code (original DCN adjustments)	C
23	Prior authorization number	C
24a	Date(s) of service	R
24b	Place of service	R
24c	EMG	C
24d	Procedures, services, or supplies/modifiers	R
24e	Diagnosis pointer	R
24f	Charges	R
24g	Days or units	R
24h	EPSDT (family plan)	C
24i	Rendering provider other ID number (must be reported with one of the NUCC qualifiers)	C
24j	Rendering provider NPI ID number	C

Billing Requirements for CMS-1500 Form (Version 8-05 New Form)		
Field	**Field Description**	**R (Required) C (Conditional) O (Optional)**
25	Federal tax ID number	R
26	Provider's patient account number	C
27	Accept assignment (assumed yes by Jefferson Health Plans contract)	C
28	Total charge	R
29	Amount paid	C
30	Balance due	C
31	Signature of physician or supplier	R
32	Service facility location information	C
32a	NPI number of the service facility location	C
32b	Other ID number (must be reported with one of the NUCC qualifiers)	C
33	Billing provider name, address, zip code, and phone number	R
33a	Billing/Group NPI	R
33b	Non-NPI—Other ID number (must be reported with one of the NUCC qualifiers)	O

UB-04 Claim Form



Billing Requirements for UB-04 Claim Form R (Required) | C (Conditional) | O (Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
1	Provider name, address and telephone, county code	R	R
2	Pay-to name, address, pay-to ID	O	O
3a	Patient control number	R	R
3b	Medical record number	R	R
4	Type of bill	R	R
5	Federal tax number	R	R
6	Statement coverage period	R	R
7	Unlabeled	O	O
8a	Patient ID	O	O
8b	Patient name	R	R
9	Patient address and county code	R	R
10	Patient date of birth	R	R
11	Patient sex	R	R
12	Admission date of service	R	R
13	Admission hour	R	C
14	Type of admission/visit	R	C
15	Source of admission	R	R
16	Discharge hour	R	C
17	Patient discharge status	R	R
18-28	Condition codes	R	R

Billing Requirements for UB-04 Claim Form R (Required) | C (Conditional) | O (Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
29	Accident state	C	C
30	Unlabeled	O	O
31-34	Occurrence code/date	C	C
35-36	Occurrence span code and dates	C	C
37	Unlabeled	O	O
38	Responsible party name/address	R	R
39-41	Value codes and amounts	C	C
42	Revenue code	R	R
43	Revenue description	R	R
44	CPT/HCPC Code, Modifier (if applicable) and Charge Amount	C	R
45	Service date	N/A	R
46	Units of service	R	R
47	Total charges by revenue code category	R	R
48	Non-covered charges	O	O
49	Unlabeled	O	O
50a	Payer name – primary	R	R
50b	Payer name – secondary	C	C
50c	Payer name – tertiary	C	C
51	Health Plan ID (Jefferson Health Plans Provider ID)	O	O
52	Release of information certification number	R	R

Billing Requirements for UB-04 Claim Form R (Required) | C (Conditional) | O (Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
53a	Assignment of benefits – primary	R	R
53b	Assignment of benefits – secondary	R	R
53c	Assignment of benefits – tertiary	R	R
54	Prior payment – payer and patient (a-c)	C	C
55	Estimated amount due	R	R
56	NPI billing provider (HIPAA provider number)	R	R
57	Non-NPI – Other ID number billing provider (must be reported with one of the NUCC qualifiers)	O	O
58	Insured's name	R	R
59	Patient's relationship	R	R
60	Insured's unique ID (HPP/Jefferson Health Plans ID number)	R	R
61	Insured's group name, if applicable	C	C
62	Insured's group number	C	C
63	Treatment authorization code	R	R
64	Document control number	C	C
65	Employer name	C	C
66	DX version qualifier (ICDv)	C	C
67	Principal diagnosis code	R	R
67a-q	Other diagnosis	C	C
68	Unlabeled	O	O
69	Admitting diagnosis code	R	N/A

Billing Requirements for UB-04 Claim Form R (Required) | C (Conditional) | O (Optional)			
Field	**Field Description**	**Inpatient**	**Outpatient**
70	Patient's reason for visit code	C	C
71	PPS code - DRG code	R	C
72	External cause of injury code	C	C
73	Unlabeled	O	O
74a-e	Other procedure code/dates	C	C
75	Unlabeled	O	O
76	Attending NPI qualifier/ID number (first field NPI, second field qual + ID)	R	R
77	Operating physician NPI qualifier/ID number (first field NPI, second field qual + ID)	C	C
78	Other - qualifier/NPI qualifier/ID	C	C
79	Other - qualifier/NPI qualifier/ID	C	C
80	Remarks	O	O
81	Code-code-qualifier/code/value	C	C