Submission Example

Please refer to the NUCC (National Uniform Claim Committee Guide) for complete detailed information on paper claim submission as well as the 837 Professional Implementation Guide for any Electronic Data Interchange (EDI) issues.

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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 N... AN NAME OR PROGRAM NAME

d. INSURANCE PLAN ...THER HEALTH BENEFIT PLAN? NO *If yes*, complete items 9, 9a, and 9d.

12. PATIENT'S OR AU... to process this clai... below. SIGNED

... AUTHORIZED PERSON'S SIGNATURE I authorize ...dical benefits to the undersigned physician or supplier for ...bed below.

The name of the Referring, Ordering or Supervising provider is entered in Box 17.
If Box 17 is populated with a name then the qualifier must be placed in the left section of Box 17.
Example: DN|Donald Duck
Qualifiers: DN - Referring, DK - Ordering, DQ - Supervising
The provider's NPI must be listed in Box 17b.
The provider's Taxonomy Code can be entered in Box 17a with the qualifier ZZ preceding the 10 character Taxonomy Code

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
DN Donald Duck

17a. ZZ 1234567890

17b. NPI 9876540123

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

The ICD Ind Box must contain a 9 for ICD-9 or 0 for ICD-10. ICD-10 will not be accepted until mandated by CMS.

YES NO

... below (24E) ICD Ind. 9

22. RESUBMISSION CODE ORIGINAL

D.

H.

L.

NDC- National Drug Code
The Provider should populate a valid NDC for drugs. The code must be entered in the shade area of Box 24. The "N4" qualifier must precede the 11 digit NDC code. No spaces or dashes are allowed.

If Rendering Provider is populated in Box 31 then the Rendering Provider's NPI is Required in Box 24J

Rendering Provider's Taxonomy Code is entered in Box 24J (shaded area) and the "ZZ" qualifier in 24I
Note: Do not populate 24J if Box 31 and 33 are the same.

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										ZZ	1234567890
										NPI	9012345678
2										NPI	
3										NPI	
4											
5											
6											

Service Location Box 32
Address MUST be the physical address where services were rendered.
Address can NEVER be a PO Box address.
Address is required when different from the Bill To Address.
Address is not required if the place of service is 12 or 15 (Home or Mobile Unit).

Bill to Provider Box 33 requires mailing address (where the provider wants the payments to go)
Box 33a requires NPI of the Bill To Provider
Box 33b - Taxonomy code preceded with "ZZ" qualifier of the Bill To Provider

Federal Tax ID Box 25
Federal Tax ID Number is required.

25. FEDERAL TAX I.D. NUMBER SSN EIN
9 digit Federal Tax ID

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.)
Rendering Provider's LastName, FirstName
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Service Facility Name
Physical Location
City, State, Zip
a. NPI of Service Facility b.

33. BILLING PROVIDER INFO & PH # ( )
Billing Provider Name
Payment Location
City, State, Zip
NPI of Billing Provider b. ZZ qualifier 10 digit Taxonomy Code

PHYSICIAN OR SUPPLIER INFORMATION

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