



# Submission Sample

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Please refer to NUCC (National Uniform Claim Committee for complete detailed information about paper claim submission and refer to the 837 Professional Implementation Guide by Washington Publishing Company (March 2003) for any EDI related issues.

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										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 <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																			
ZIP CODE					TELEPHONE (Include Area Code)					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code)																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> NO <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
d. INSURANCE PLAN NAME										12. PATIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____										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 MM DD YY										15. NAME OF CURRENT ILLNESS										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD TO MM DD																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Referring Provider's Last name, First name										17a. ZZ 10 character Taxonomy					17b. NPI 10 digit NPI					18. HOSPITALIZATION FROM MM DD TO MM DD																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE OF STATE <input type="checkbox"/> YES <input type="checkbox"/> NO										21. BILL TO PROVIDER a. BILLING PROVIDER'S NAME (last, first) b. BILLING PROVIDER'S ADDRESS (last, first) c. BILLING PROVIDER'S CITY, STATE, ZIP CODE																			
NDC - National Drug Code Paper - The Provider should populate a valid National Drug Code (NDC) - the code must be entered in the shade area of Box 24. The "N4" qualifier should precede the 11 digit NDC code. No spaces or dashes are allowed. EDI - Loop 2410 Segment LIN Element: N4 (5-4--2 format)										Rendering Provider's NPI Paper - If Rendering Provider is Populated in Box 31 then Rendering Provider's NPI is Required in Box 24J EDI - Loop 2310B NM108 = XX NM109										Rendering Provider's Taxonomy Paper - Is Required in Box 24J (shaded area) and the "ZZ" qualifier is required in 24i when a Rendering Provider's NPI is populated. EDI - Loop 2310B PRV01 "PE" = Performing PRV02 - "ZZ" qualifier PRV03 = 10 character taxonomy code  Note: Do not populate 24J if Box 31 and 33 are the same.																			
Federal Tax ID Paper - Federal Tax ID Number is required. EDI - Loop 2010AA element REF02 EDI Qualifier element REF01=E1										Service Location Paper - Address MUST be the physical address where services were rendered. Address can NEVER be a PO Box address. Address is not required if the place of service id 12 or 15 (Home or Mobile Unit). EDI - EDI Loop 2310D Segment NM1 Qualifier 77										Bill to Provider Paper - Box 33 requires mailing address (where the provider wants the payments to go) Box 33a requires NPI of the Bill To Provider Box 33b requires Taxonomy code preceded with "ZZ" qualifier of the Bill To Provider EDI - Loop 2010AA Segment NM1 Qualifier 85 NM108 = XX NM109 = 10 digit valid NPI number Loop 2000A - (Taxonomy code) PRV01 "BI" PRV02 - "ZZ" qualifier PRV03 = 10 character taxonomy code																			
25. FEDERAL TAX I.D. NUMBER 9 digit Federal Tax ID										SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPTED ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$				
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 Last Name, First Name SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION Service Facility Name (last, first) 456 Physical Location Rd Suite A Macon, GA 31201										33. BILLING PROVIDER INFO & PH # Organizational Name (last, first) 123 Payment Way Suite 1 Macon, GA 31201																			
										a. NPI					b. 10 digit NPI					a. 10 digit NPI					b. 10 character Taxonomy preceded with "ZZ" qualifier														