# National Uniform Claim Committee



1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12

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Version 9.0 7/21

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The 1500 Health Insurance Claim Form (1500 Claim Form) is in the public domain.

The NUCC has developed this general instructions document for completing the 1500 Claim Form. This document is intended to be a guide for completing the 1500 Claim Form and not definitive instructions for this purpose. Any user of this document should refer to the most current federal, state, or other payer instructions for specific requirements applicable to using the 1500 Claim Form.

The NUCC Reference Instruction Manual must remain intact. Any payer-specific instructions for completion of the 1500 Claim Form need to be maintained in a separate document.

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#### **1500 Claim Form Citation**

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# **BACKGROUND INFORMATION**

The 1500 Health Insurance Claim Form (1500 Claim Form) answers the needs of many health care payers. It is the basic paper claim form prescribed by many payers for claims submitted by physicians, other providers, and suppliers, and in some cases, for ambulance services.

In the 1960s, there were a number of different claim forms and coding systems required by third-party payers to communicate information regarding procedures and services to agencies concerned with insurance claims. There was, however, no standardized form for physicians and other health care providers to report health care services. Therefore, the American Medical Association (AMA) embraced an assignment in the 1980s to work with the Centers for Medicare & Medicaid Services (CMS; formerly known as HCFA), and many other payer organizations through a group called the Uniform Claim Form Task Force to standardize and promote the use of a universal health claim form. As a result of this joint effort, the 1500 Claim Form is accepted nationwide by most insurance entities as the standard claim form/attending physician statement for submission of medical claims.

The Uniform Claim Form Task Force was replaced by the National Uniform Claim Committee (NUCC) in the mid 1990s. The NUCC's goal was to develop the NUCC Data Set (NUCC-DS), a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The NUCC continues to be responsible for the maintenance of the 1500 Claim Form. Although many providers now submit electronic claims, many of their software/hardware systems depend on the existing 1500 Claim Form in its current image.

# **SCOPE OF INSTRUCTIONS**

This NUCC Reference Instruction Manual provides specific instructions on how to complete the 1500 Claim Form. Instructions and information provided align with the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837), 005010X222 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1). 5010 and 5010A1 are collectively referred to as "5010A1" in this manual.

The 1500 Claim Form instructions were initially approved by the NUCC in November 2005. The NUCC continues to research the type of data that are typically reported, as well as the required data elements that may apply to public and private payers. Therefore, the instructions have and will continue to evolve. Updated versions of this instruction manual are released each July. The ultimate goal of the NUCC is to develop standardized national instructions. The end result may require additional changes to the 1500 Claim Form in the future.

The instructions in this manual are not specific to any applicable public or private payer. Refer to specific instructions issued by your payer, clearinghouse, and/or vendor for further clarification of reporting requirements.

The 1500 Claim Form may also be used to report patient encounter data to federal, state, and/or other public health agencies. Refer to instructions issued by these agencies for further clarification of reporting requirements.

# **ONLINE RESOURCES**

The NUCC Reference Instruction Manual, Change Log, and a form to request changes to the manual are available at: <a href="https://www.nucc.org">www.nucc.org</a>.



# **HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	02/12	
PICA		PICA
	— HEALTH PLAN — BLK LUNG —	OTHER 1a, INSURED'S LD, NUMBER (For Program in Item 1)
	fember ID#) (ID#) (ID#) (ID#)	(D#)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self Spouse Child Other	
CITY S	STATE 8. RESERVED FOR NUCC USE	CITY
ZIP CODE TELEPHONE (Include Area Code	a)	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)	a, INSURED'S DATE OF BIRTH MM   DD   YY
	YES NO	M F
b, RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (S	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c, OTHER ACCIDENT?	c, INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d, CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO ## yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMP	PLETING & SIGNING THIS FORM.	
READ BACK OF FORM BEFORE COMP  12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I author to process this claim. I also request payment of government benefit below.	rize the release of any medical or other information neces is either to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMR MM   DD   YY QUAL.	P) 15. OTHER DATE   MM   DD   YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM DD YY  FROM DD TO  MM DD TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18, HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
	17b. NPI	FROM DD YY MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	to service line below (24E) ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. L. B. L.	C, L D, L	23, PRIOR AUTHORIZATION NUMBER
F. F.	G. H. H.	23. FRION AUTHORIZATION NUMBER
1.	PROCEDURES, SERVICES, OR SUPPLIES E	F. G. H. I. J. NOSIS DAYS EPSUT IN RENDERING
From To PLACE OF	(Explain Unusual Circumstances) DIAGI PT/HCPCS   MODIFIER POIN	
		NPI
		NPI NPI
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIE	ENT'S ACCOUNT NO. 27. ACCEPT ASSIGNME	
	(For govt. claims, see back	s s
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,)	JICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	NPI b.	a. NPI h
NUCC Instruction Manual available at: www.nucc.org	n PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-12

# **OVERALL INSTRUCTIONS**

Each Item Number includes the title, instructions, description, field specifications, and example. The examples provided in the instructions are demonstrating how to enter the data in the field. They are not providing instruction on how to bill for certain services.

# **PUNCTUATION**

The use of punctuation is noted in the instructions section of each Item Number.

#### **MULTIPLE PAGE CLAIMS**

When reporting line item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim. If there are more than 50 service lines, the claim must be split.

**NOTE 1**: Form images throughout this manual may not be to scale.

**NOTE 2:** Data content entered into fields may not fill all allotted space.

# FIELD SPECIFIC INSTRUCTIONS

# **CARRIER BLOCK**

The carrier block is located in the upper center and right margin of the form. In order to distinguish this version of the form from previous versions, the Quick Response (QR) code symbol and the date approved by the NUCC have been added to the top, left-hand margin.

HEALTH INSURANCE CLAIM FORM	i i
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	Č
PICA	PICA

**INSTRUCTIONS:** Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format:

1<sup>st</sup> Line – Name

2<sup>nd</sup> Line – First line of address

3<sup>rd</sup> Line – Second line of address, if necessary

4<sup>th</sup> Line – City, State (2 characters) and ZIP code

Line	Descriptor	Type	Bytes	Columns
4	Payer Name	A/N	41	38-78
5	Payer Address 1	A/N	41	38-78
6	Payer Address 2	A/N	41	38-78
7	Payer City State and ZIP	A/N	41	38-78

For an address with three lines, enter it in the following format:

1st Line – Name

2nd Line – Line of address

3rd Line – Leave blank

4th Line – City, State (2 characters) and ZIP code

Line	Descriptor	Type	Bytes	Columns
4	Payer Name	A/N	41	38-78
5	Payer Address	A/N	41	38-78
6	Leave blank			
7	Payer City State and ZIP	A/N	41	38-78

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

When printing page numbers on multiple page claims (generally done by clearinghouses when converting 5010A1 to the 1500 Claim Form), print the page numbers in the Carrier Block on Line 8 beginning at column 32. Page numbers are to be printed as:

Page XX of YY

**DESCRIPTION:** The payer is the carrier, health plan, third-party administrator, or other payer that will handle the claim. This information directs the claim to the appropriate payer.

# **EXAMPLES:**

# Four line address:

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/	12 Page 01 of 02	ABC Insurance Company Suite 600 567 Insurance Lane Big City IL 60605	↓ CARRIER
Three line address:		·	
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02	r12	ABC Insurance Company 567 Insurance Lane Big City IL 60605	CABRIFR
PICA	Page 01 of 02	Dig Oity IL 00000	PICA CTTT

# ITEMS 1–13: PATIENT AND INSURED INFORMATION

**Note:** If the patient can be identified by a unique Member Identification Number, the patient is considered to be the "insured". The patient is reported as the insured in the insured data fields and not in the patient fields.

# **ITEM NUMBER 1**

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

TITLE: Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other

**INSTRUCTIONS:** Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.

**DESCRIPTION:** "Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other" means the insurance type to which the claim is being submitted. "Other" indicates health insurance including HMOs, commercial insurance, automobile accident, liability, or workers' compensation. This information directs the claim to the correct program and may establish primary liability.

FIELD SPECIFICATION: This field allows for entry of 1 character in any box within the field.

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

#### **ITEM NUMBER 1a**

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

TITLE: Insured's ID Number

**INSTRUCTIONS:** Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field.

FOR TRICARE: Enter the DoD Benefits Number (DBN 11-digit number) from the back of the ID card.

**FOR WORKERS COMPENSATION CLAIMS:** Enter the appropriate identifier of the employee.

**FOR OTHER PROPERTY AND CASUALTY CLAIMS:** Enter the appropriate identifier of the insured person or entity.

**DESCRIPTION:** The "Insured's ID Number" is the identification number of the insured. This information identifies the insured to the payer.

**FIELD SPECIFICATION:** This field allows for entry of 29 characters.

#### **EXAMPLE:**

1a. INSURED'S I.D. NUMBER	(For Program in Hem 1)
X0123456789	

#### **ITEM NUMBER 2**

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

**TITLE:** Patient's Name

**INSTRUCTIONS:** Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

If the patient's name is the same as the insured's name (i.e., the patient is the insured), then it is not necessary to report the patient's name.

**DESCRIPTION:** The "Patient's Name" is the name of the person who received the treatment or supplies.

**FIELD SPECIFICATION:** This field allows for the entry of 28 characters.

# **EXAMPLE:**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe Jr, John, J



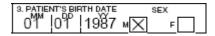
TITLE: Patient's Birth Date, Sex

**INSTRUCTIONS:** Enter the patient's 8-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank.

**DESCRIPTION:** The "Patient's Birth Date, Sex" is information that will identify the patient and it distinguishes persons with similar names.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 1 character in either box.

#### **EXAMPLE:**



#### **ITEM NUMBER 4**

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

**TITLE:** Insured's Name

**INSTRUCTIONS:** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

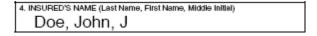
Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

FOR WORKERS COMPENSATION CLAIMS: Enter the name of the Employer.

FOR OTHER PROPERTY & CASUALTY CLAIMS: Enter the name of the insured person or entity.

**DESCRIPTION:** The "Insured's Name" identifies the person who holds the policy, which would be the employee for employer-provided health insurance.

FIELD SPECIFICATION: This field allows for the entry of 29 characters.



5. PATIENT'S ADDRESS (No., St	treet)	
СПУ		STATE
ZIP CODE	TELEPHONE (Include Area Cor	de)
	( )	

TITLE: Patient's Address (multiple fields)

**INSTRUCTIONS:** Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

If the patient's address is the same as the insured's address, then it is not necessary to report the patient's address.

"Patient's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extensions are not supported.

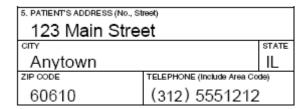
**FOR WORKERS' COMPENSATION AND OTHER PROPERTY AND CASUALTY CLAIMS:** If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

**DESCRIPTION:** The "Patient's Address" is the patient's permanent residence. A temporary address or school address should not be used.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 28 characters for street address, 24 characters for city, 3 characters for state, 12 digits for ZIP code, 3 digits for area code, and 10 digits for phone number.

#### **EXAMPLE:**

With phone number, if required.



6. PATIENT RELATIONSHIP TO INSURED						
Self	Spouse	Child	Other			

TITLE: Patient Relationship to Insured

**INSTRUCTIONS:** Enter an X in the correct box to indicate the patient's relationship to insured when Item Number 4 is completed. Only one box can be marked.

If the patient is a dependent, but has a unique Member Identification Number and the payer requires the identification number be reported on the claim, then report "Self", since the patient is reported as the insured.

**DESCRIPTION:** The "Patient Relationship to Insured" indicates how the patient is related to the insured. "Self" would indicate that the insured is the patient. "Spouse" would indicate that the patient is the husband or wife or qualified partner, as defined by the insured's plan. "Child" would indicate that the patient is the minor dependent, as defined by the insured's plan. "Other" would indicate that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured's plan.

FIELD SPECIFICATION: This field allows for entry of 1 character in any box within the field.

6. PATIENT	RELATION	ASHIP TO INS	URED	 _
Self	Spouse	child 🗙	Other	

7. INSURED'S ADDRESS	(No., Street)
СПУ	STATE
ZIP CODE	TELEPHONE (Include Area Code)

**TITLE:** Insured's Address (multiple fields)

**INSTRUCTIONS:** Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

"Insured's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extensions are not supported.

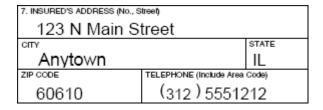
**FOR WORKERS COMPENSATION CLAIMS:** Enter the address of the Employer.

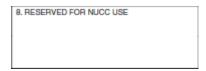
**FOR OTHER PROPERTY AND CASUALTY CLAIMS:** Enter the address of the insured noted in Item Number 4.

**FOR WORKERS' COMPENSATION AND OTHER PROPERTY AND CASUALTY CLAIMS:** If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

**DESCRIPTION:** The "Insured's Address" is the insured's permanent residence, which may be different from the patient's address in Item Number 5.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 29 characters for street address, 23 characters for city, 4 characters for state, 12 digits for ZIP code, 3 digits for area code, and 10 digits for phone number.





TITLE: Reserved for NUCC Use

**INSTRUCTIONS:** This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

**DESCRIPTION:** This field is reserved for NUCC use.

FIELD SPECIFICATION: None

**EXAMPLE:** None

#### **ITEM NUMBER 9**

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

TITLE: Other Insured's Name

**Instructions:** If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

**DESCRIPTION:** The "Other Insured's Name" indicates that there is a holder of another policy that may cover the patient.

**FIELD SPECIFICATION:** This field allows for the entry of 28 characters.

# **EXAMPLE:**

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

Doe, Mary, A

# **ITEM NUMBER 9a**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

**TITLE:** Other Insured's Policy or Group Number

**INSTRUCTIONS:** Enter the policy or group number of the other insured.

Do not use a hyphen or space as a separator within the policy or group number.

**DESCRIPTION:** The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9.

**FIELD SPECIFICATION:** This field allows for the entry of 28 characters.

# **EXAMPLE:**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

X9876543210

# **ITEM NUMBER 9b**

b. RESERVED FOR NUCC USE

TITLE: Reserved for NUCC Use

**INSTRUCTIONS:** This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

**DESCRIPTION:** This field is reserved for NUCC use.

**FIELD SPECIFICATION: None** 

**EXAMPLE:** None

# **ITEM NUMBER 9c**

c. RESERVED FOR NUCC USE

TITLE: Reserved for NUCC Use

**INSTRUCTIONS:** This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

**DESCRIPTION:** This field is reserved for NUCC use.

FIELD SPECIFICATION: None

**EXAMPLE:** None

#### **ITEM NUMBER 9d**

d. INSURANCE PLAN NAME OR PROGRAM NAME

**TITLE:** Insurance Plan Name or Program Name

**INSTRUCTIONS:** Enter the other insured's insurance plan or program name.

**DESCRIPTION:** The "Insurance Plan Name or Program Name" identifies the name of the plan or program of the other insured as indicated in Item Number 9.

FIELD SPECIFICATION: This field allows for the entry of 28 characters.

# **EXAMPLE:**

d. INSURANCE PLAN NAME OR PROGRAM NAME

XYZ Insurance Company

# ITEM NUMBERS 10a-10c

10. IS PATIENT'S CONDIT	TION RELATED TO:
a. EMPLOYMENT? (Ourre	ent or Previous)
YES	NO
b. AUTO ACCIDENT?	PLACE (State)
YES	NO L
c. OTHER ACCIDENT?	
YES	NO

**TITLE:** Is Patient's Condition Related To:

**INSTRUCTIONS:** When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.

The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.

**DESCRIPTION:** This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. "Employment (current or previous)" would indicate that the condition is related to the patient's job or workplace. "Auto accident" would indicate that the condition is the result of an automobile accident. "Other accident" would indicate that the condition is the result of any other type of accident.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 1 character in either box per each line and 2 characters in the Place/State field.

10. IS PATIENT'S CONDI	TION RELATED TO:
a. EMPLOYMENT? (Curre	ent or Previous)
YES	× NO
b. AUTO ACCIDENT?	PLACE (State)
YES	× №
c. OTHER ACCIDENT?	
YES	× NO

#### **ITEM NUMBER 10d**

10d. CLAIM CODES (Designated by NUCC)

**TITLE:** Claim Codes (Designated by NUCC)

**INSTRUCTIONS:** When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.

When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at <a href="https://www.nucc.org">www.nucc.org</a> under Code Sets.

When reporting more than one code, enter three blank spaces and then the next code.

**FOR WORKERS COMPENSATION CLAIMS:** Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these situations). Note: Do not use Condition Codes when submitting a revised or corrected bill.

**DESCRIPTION:** The "Claim Codes" identify additional information about the patient's condition or the claim.

FIELD SPECIFICATION: This field allows for the entry of 19 characters.

#### **EXAMPLE:**

10d. CLAIM CODES (Designated by NUCC)
W2

# **ITEM NUMBER 11**

11. INSURED'S POLICY GROUP OR FECA NUMBER

TITLE: Insured's Policy, Group, or FECA Number

**INSTRUCTIONS:** Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed.

Do not use a hyphen or space as a separator within the policy or group number.

**DESCRIPTION:** The "Insured's Policy, Group, or FECA Number" is the alphanumeric identifier for the health, auto, or other insurance plan coverage. The FECA number is the 9-character alphanumeric identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101.

FIELD SPECIFICATION: This field allows for the entry of 29 characters.

# **EXAMPLE:**

11. INSURED'S POLICY GROUP OR FECA NUMBER
A1234
Version 9.0

# **ITEM NUMBER 11a**



TITLE: Insured's Date of Birth, Sex

**INSTRUCTIONS:** Enter the 8-digit date of birth (MM | DD | YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

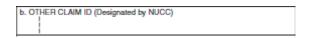
**DESCRIPTION:** The "Insured's Date of Birth, Sex" is the birth date and gender of the insured as indicated in Item Number 1a.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 1 character in either box.

#### **EXAMPLE:**



#### **ITEM NUMBER 11b**



**TITLE:** Other Claim ID (Designated by NUCC)

**INSTRUCTIONS:** Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.

When submitting to Property and Casualty payers, e.g. Automobile, Homeowner's, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:

Y4 Agency Claim Number (Property Casualty Claim Number)

Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.

**FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.

**DESCRIPTION:** The "Other Claim ID" is another identifier applicable to the claim.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 2 characters to the left of the vertical, dotted line and 28 characters to the right of the dotted line.

## **EXAMPLE:**

b. OTHER CLAIM ID (Designated by NUCC)
Y4 112233445566

#### **ITEM NUMBER 11c**

c. INSURANCE PLAN NAME OR PROGRAM NAME	

**TITLE:** Insurance Plan Name or Program Name

**INSTRUCTIONS:** Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.

**DESCRIPTION:** The "Insurance Plan Name or Program Name" is the name of the plan or program of the insured as indicated in Item Number 1a.

FIELD SPECIFICATION: This field allows for the entry of 29 characters.

# **EXAMPLE:**

c. INSURANCE PLAN NAME OR PROGRAM NAME
ABC Insurance Company

#### **ITEM NUMBER 11d**

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

TITLE: Is there another Health Benefit Plan?

**INSTRUCTIONS:** When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.

**DESCRIPTION:** "Is there another health benefit plan" indicates that the patient has insurance coverage other than the plan indicated in Item Number 1.

**FIELD SPECIFICATION:** This field allows for the entry of 1 character in either box.



TITLE: Patient's or Authorized Person's Signature

**INSTRUCTIONS:** Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File."

**DESCRIPTION:** The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

**FIELD SPECIFICATION:** Use the space available to enter signature/information and date.

#### **EXAMPLE:**

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 SOF DATE

# **ITEM NUMBER 13**

TITLE: Insured's or Authorized Person's Signature

**INSTRUCTIONS:** Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."

**DESCRIPTION:** The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits.

**FIELD SPECIFICATION:** Use the space available to enter signature/information.

# **EXAMPLE:**

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

SIGNED SOF

# ITEMS 14-33: PHYSICIAN OR SUPPLIER INFORMATION

# **ITEM NUMBER 14**

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

TITLE: Date of Current Illness, Injury, or Pregnancy (LMP)

**INSTRUCTIONS:** Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

Enter the applicable qualifier to identify which date is being reported.

- 431 Onset of Current Symptoms or Illness
- 484 Last Menstrual Period

Enter the qualifier to the right of the vertical, dotted line.

**DESCRIPTION:** The "Date of Current Illness, Injury, or Pregnancy" identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 2 digits under MM, 2 digits under DD, 4 digits under YY, and 3 characters to the right of the vertical, dotted line.

14. DATE O	ECURRENT ILLI	NESS, INJURY, or PREGNANCY (LMP)
09 3	0  2005	QUAL: 431

15. OTHER DATE QUAL.	MM   DD	YY

**TITLE:** Other Date

**INSTRUCTIONS:** Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format.

Enter the applicable qualifier to identify which date is being reported.

454	Initial Treatment
304	Latest Visit or Consultation
453	Acute Manifestation of a Chronic Condition
439	Accident
455	Last X-ray
471	Prescription
090	Report Start (Assumed Care Date)
091	Report End (Relinquished Care Date)
444	First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

**DESCRIPTION:** The "Other Date" identifies additional date information about the patient's condition or treatment.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 3 characters between the vertical, dotted lines, 2 digits under MM, 2 digits under DD, and 4 digits under YY.

15. OTHER DATE	
	MM   DD   YY
QUAL. 151	00 25 2005
454	09 25 2005

16. DATES PATI	ENT UNABLE TO	WORK IN CURREN	TOGGI	UPATION YY
FROM	i i	TO		İ

**TITLE:** Dates Patient Unable to Work in Current Occupation

**INSTRUCTIONS:** If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date must be shown for the "from—to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

**DESCRIPTION:** "Dates Patient Unable to Work in Current Occupation" is the time span the patient is or was unable to work.

**FIELD SPECIFICATION:** This field allows for the entry of the following in each of the date fields: 2 digits under MM, 2 digits under DD, and 4 digits under YY.

16. DATES PATIEN	T UNABLE TO WOR	K IN CURREN	посс	UPATION
FROM 09 2	B 12006	то 10°	lo8o	30VE
FROM US   2	:0  ZUU5	10 10	20	2005

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

**TITLE:** Name of Referring Provider or Other Source

**INSTRUCTIONS:** Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

- 1. Referring Provider
- 2. Ordering Provider
- 3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider

DK Ordering Provider

DQ Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

**DESCRIPTION:** The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported.

**FIELD SPECIFICATION:** This field allows for the entry of 2 characters to the left of the vertical, dotted line and 24 characters to the right of the dotted line.

# **EXAMPLE:**

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

DN Jane A Smith MD

# ITEM NUMBER 17a AND 17b (Split Field)

17a.		
17b.	NPI	

TITLE 17a: Other ID#

**INSTRUCTIONS 17a:** The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

- OB State License Number
- 1G Provider UPIN Number
- G2 Provider Commercial Number
- LU Location Number (This qualifier is used for Supervising Provider only.)

**DESCRIPTION:** The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional.

**FIELD SPECIFICATION:** This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.

**TITLE 17b:** NPI #

**INSTRUCTIONS 17b:** Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

**DESCRIPTION:** The NPI number refers to the HIPAA National Provider Identifier number.

**FIELD SPECIFICATION:** This field allows for the entry of a 10-digit NPI number.

	17a.	G2	ABC1234567890
Γ	17b.	NPI	0123456789

		TES RELATED TO CURRE	NT SER	(VICES
MM	DD	YY MM	DD	YY
FROM		то	i	

**TITLE:** Hospitalization Dates Related to Current Services

**INSTRUCTIONS:** Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

**DESCRIPTION:** The "Hospitalization Dates Related to Current Services" refers to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

**FIELD SPECIFICATION:** This field allows for the entry of the following in each of the date fields: 2 digits under MM, 2 digits under DD, and 4 digits under YY.

#### **EXAMPLE:**

```
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES OF PROM 09 25 2005 TO 09 28 2005
```

#### **ITEM NUMBER 19**

```
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
```

**TITLE:** Additional Claim Information (Designated by NUCC)

**INSTRUCTIONS:** Please refer to the most current instructions from the public or private payer regarding the use of this field. Report the appropriate qualifier, when available, for the information being entered. Do not enter a space, hyphen, or other separator between the qualifier and the information.

For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier "NTE", followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words.

ADD Additional Information
CER Certification Narrative
DCP Goals, Rehabilitation Potential, or Discharge Plans
DGN Diagnosis Description
TPO Third Party Organization Notes

#### **EXAMPLE:**

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

NTEADDSurgery was unusually long due to scarring

For additional identifiers (REFs), the following are the qualifiers in 5010A1. Enter the qualifier "REF", followed by the qualifier, then the identifier. Do not enter spaces between the qualifier and identifier.

- 0B State License Number 1G Provider UPIN Number
- G2 Provider Commercial Number
- LU Location Number (This qualifier is used for Supervising Provider only.)
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The social security number may not be used for Medicare.)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

Taxonomy codes or other identifiers reported in this field must not be reportable in other fields, i.e., Item Numbers 17, 24J, 32, or 33.

## **EXAMPLE:**

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
REFG21234567890

For Supplemental Claim Information (PWK), the following are the qualifiers in the 5010A1. Enter the qualifier "PWK", followed by the appropriate Report Type Code, the appropriate Transmission Type Code, then the Attachment Control Number. Do not enter spaces between the qualifiers and data.

# **REPORT TYPE CODES**

- 03 Report Justifying Treatment Beyond Utilization
- 04 Drugs Administered
- 05 Treatment Diagnosis
- 06 Initial Assessment
- 07 Functional Goals
- 08 Plan of Treatment
- 09 Progress Report
- 10 Continued Treatment
- 11 Chemical Analysis
- 13 Certified Test Report
- 15 Justification for Admission
- 21 Recovery Plan
- A3 Allergies/Sensitivities Document
- A4 Autopsy Report
- AM Ambulance Certification
- AS Admission Summary
- B2 Prescription
- B3 Physician Order
- B4 Referral Form
- BR Benchmark Testing Results

- BS Baseline
- BT Blanket Test Results
- CB Chiropractic Justification
- CK Consent Form(s)
- CT Certification
- D2 Drug Profile Document
- DA Dental Models
- DB Durable Medical Equipment Prescription
- DG Diagnostic Report
- DJ Discharge Monitoring Report
- DS Discharge Summary
- EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
- HC Health Certificate
  HR Health Clinic Records
- 15 Immunization Record
- IR State School Immunization Records
- LA Laboratory Results
- M1 Medical Record Attachment
- MT Models
- NN Nursing Notes
- OB Operative Note
- OC Oxygen Content Averaging Report
- OD Orders and Treatments Document
- OE Objective Physical Examination (including vital signs) Document
- OX Oxygen Therapy Certification
- OZ Support Data for Claim
- P4 Pathology Report
- P5 Patient Medical History Document
- PE Parenteral or Enteral Certification
- PN Physical Therapy Notes
- PO Prosthetics or Orthotic Certification
- PQ Paramedical Results
- PY Physician's Report
- PZ Physical Therapy Certification
- RB Radiology Films
- RR Radiology Reports
- RT Report of Tests and Analysis Report
- RX Renewable Oxygen Content Averaging Report
- SG Symptoms Document
- V5 Death Notification
- XP Photographs

# TRANSMISSION TYPE CODES

- AA Available on Request at Provider Site
- BM By Mail

# **EXAMPLE:**

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

PWK03AA12363545465

When reporting multiple separate items, enter three blank spaces and then the next qualifier and followed by the information

Version 9.0

#### **EXAMPLE:**

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

NTEADD Surgery was unusually long due to scarring PWKOBBM1213141

**DESCRIPTION:** "Additional Claim Information" identifies additional information about the patient's condition or the claim.

FIELD SPECIFICATION: This field allows for the entry of 71 characters.

## **ITEM NUMBER 20**

20. OUTSIDE LAB?	\$ CHARGES	
YES NO		

**TITLE:** Outside Lab? \$Charges

**INSTRUCTIONS:** Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim.

If "YES" is marked, enter the purchase price under "\$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.

When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

**DESCRIPTION:** "Outside lab? \$Charges" indicates that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 1 character in either box in the Outside Lab area and 8 characters to the left of the vertical line in the \$Charges area.



21. DIAGNOSIS OR NATURE	OF ILLNESS OR INJURY Relate	A-L to service line below (24E)	ICD Ind.
A	В.	C	D
E	F	G	н
I.	J	К.	L

**TITLE:** Diagnosis or Nature of Illness or Injury

**INSTRUCTIONS:** Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- 9 ICD-9-CM
- 0 ICD-10-CM

Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.

Enter the codes left justified on each line to identify the patient's diagnosis or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than 12 ICD-10-CM or ICD-9-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.

**DESCRIPTION:** The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

**FIELD SPECIFICATION:** This field allows for the entry a 1 digit indicator and 12 diagnosis codes at a maximum of 7 characters in length.

# **EXAMPLE:**

#### ICD-10-CM:

21. DIAGNOSIS OR NATU	RE OF ILLNESS OR INJURY Relate	e A-L to service line below (24E)	ICD Ind.
<sub>A.</sub> O139	<sub>в. (</sub> O6012x0	c. J0190	n l
E	F. L	G. L	н. I
L	J	K	L

#### ICD-9-CM:

21. DIAGNOSIS OR NATUR	RE OF ILLNESS OR INJURY Re	elate A-L to service line below (24E)	ICD Ind. 9	
A. <u>99859</u>	<sub>B. 1</sub> 7806	c. V180	<sub>D.</sub> E8788	
E	F. L	G. L	н	
I. <u>L</u>	J	K	L. L	

TITLE: Resubmission and/or Original Reference Number

**INSTRUCTIONS:** List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field.

When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

- 7 Replacement of prior claim
- 8 Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

**DESCRIPTION:** "Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

**FIELD SPECIFICATION:** This field allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. area.

# **EXAMPLE:**

22. BESUBMISSION 7	ORIGINAL REF. NO. ABC 1234567890
--------------------	-------------------------------------

#### **ITEM NUMBER 23**



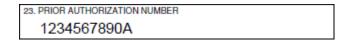
**TITLE: Prior Authorization Number** 

**INSTRUCTIONS:** Enter any of the following: prior authorization number, referral number, mammography certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

Do not enter hyphens or spaces within the number.

**DESCRIPTION:** The "Prior Authorization Number" is the payer assigned number authorizing the service(s).

**FIELD SPECIFICATION:** This field allows for the entry of 29 characters.



# **SECTION 24**

	24. A. MM	From DD	TE(S) C	F SER	VICE To DD		B. PLACE OF SERVICE	D. PROCEDURE (Explain Unu CPT/HCPCS	S, SERVI Isual Circu 	CES, OF Imstand MOD	es)	LIES	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Ramily Ran	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	-	- 1			ł	1			ı	ı		!	1	!		ı	NPI	
2		ı				!						!	1			1	NPI	
3	1	-				<u> </u>			i	!	1					1	NPI	
4						!					!	!					NPI	
5	ļ	-							i		!						NPI	
6	!	-				!					!						NPI	

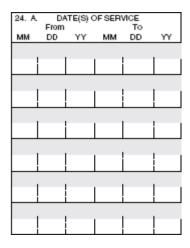
**INSTRUCTIONS:** Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. Providers must verify requirements for this supplemental information with the payer.

See page 45 for further instructions and examples of how to enter supplemental information.

**FIELD SPECIFICATION:** The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

# **ITEM NUMBER 24A**



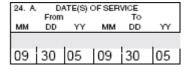
**TITLE:** Date(s) of Service [lines 1–6]

**INSTRUCTIONS:** Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G.

When required by payers to provide additional narrative description of an unspecified code, NDC, contract rate, or tooth numbers and areas of the oral cavity enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/ information. The information may extend to 24G. Further instructions on entering supplemental information with qualifiers, including examples, are on page 45.

**DESCRIPTION:** "Date(s) of Service" indicates the actual month, day, and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.

**FIELD SPECIFICATION:** This field allows for the entry of the following in each of the unshaded date fields: 2 digits under MM, 2 digits under DD, and 2 digits under YY.



ITEM NUMBER 24B
B. PLACE OF SERVICE
TITLE: Place of Service [lines 1–6]
<b>INSTRUCTIONS:</b> In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: <a href="https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html">www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html</a> .
<b>DESCRIPTION:</b> The "Place of Service" Code identifies the location where the service was rendered.
FIELD SPECIFICATION: This field allows for the entry of 2 digits in the unshaded area.
EXAMPLE:
B. PLACE OF SERVICE

#### **ITEM NUMBER 24C**

C. EMG	

**TITLE:** EMG [lines 1–6]

INSTRUCTIONS: Check with payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in 5010A1.

**DESCRIPTION:** "EMG" identifies if the service was an emergency.

**FIELD SPECIFICATION:** This field allows for the entry of 2 characters in the unshaded area.



#### **ITEM NUMBER 24D**

D. PROCEDURES (Explain Unu CPT/HCPCS	sual Circu	mstano	es)	UES
				Ш
				Ш
	Ш			Ш
				!
				Ш

**TITLE:** Procedures, Services, or Supplies [lines 1–6]

**INSTRUCTIONS:** Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description.

**DESCRIPTION:** "Procedures, Services or Supplies" identify the medical services and procedures provided to the patient.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 6 characters in the unshaded area of the CPT/HCPCS field and four sets of 2 characters in the Modifier area.

D. PROCEDURES (Explain Unu CPT/HCPCS		BS)	.IES
99241	25		

#### **ITEM NUMBER 24E**

DIAGN POIN	IOSIS TER
	П

**TITLE:** Diagnosis Pointer [lines 1–6]

**INSTRUCTIONS:** In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM or ICD-9-CM diagnosis codes must be entered in Item Number 21. Do not enter them in 24E.

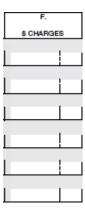
Enter letters left justified in the field. Do not use commas between the letters.

**DESCRIPTION:** The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.

**FIELD SPECIFICATION:** This field allows for the entry of 4 characters in the unshaded area.



#### **ITEM NUMBER 24F**



**TITLE:** \$Charges [lines 1–6]

**INSTRUCTIONS:** Enter the charge amount for each listed service.

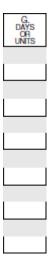
Enter the number right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area of the field if the amount is a whole number.

**DESCRIPTION:** "\$Charges" is the total billed amount for each service line.

**FIELD SPECIFICATION:** This field allows for the entry of 6 digits to the left of the vertical line and 2 digits to the right of the vertical line in the unshaded area.



#### **ITEM NUMBER 24G**



**TITLE:** Days or Units [lines 1–6]

**INSTRUCTIONS:** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

Anesthesia services <u>must</u> be reported as minutes. Units may <u>only</u> be reported for anesthesia services when the code description includes a time period (such as "daily management").

**DESCRIPTION:** "Days or Units" is the number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS coding manual(s).

FIELD SPECIFICATION: This field allows for the entry of 3 digits in the unshaded area.

# **EXAMPLES:**



1



1.5

# **ITEM NUMBER 24H**

H. ERSOT Parrily Placi	

**TITLE:** EPSDT/Family Plan [lines 1–6]

**INSTRUCTIONS:** For reporting of Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning services, refer to specific payer instructions.

#### **EPSDT**

When EPSDT services are reported on this claim, identify the status of the referral by entering one of the following reason codes right justified in the shaded area of the field.

The following codes for EPSDT are used in 5010A1:

- AV Available Not Used (Patient refused referral.)
- S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)
- ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)
- NU Not Used (Used when no EPSDT patient referral was given.)

# **Family Planning**

When there is a requirement to report this is a Family Planning service, enter Y for "YES" in the unshaded area of the field.

When there is no requirement to report this is a Family Planning service, leave the field blank.

**DESCRIPTION:** The "EPSDT/Family Plan" identifies certain services that may be covered under some state plans.

**FIELD SPECIFICATION:** This field allows for the entry of 1 character in the unshaded area and 2 characters right justified in the shaded area.

### **EXAMPLES**

EPSDT:	Family Planning – Yes:	Family Planning – No:	<b>EPSDT</b> and Family Planning:
H. EPSDT Family Plan	H. EPSDT	H. EPSDT Family	H. EPSOT Family
	Family Plan	Plan	Plan
S2			ST
	Y		Y

#### **ITEM NUMBER 24I**



**TITLE:** ID Qualifier [lines 1–6]

**INSTRUCTIONS:** Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

The NUCC defines the following qualifiers used in 5010A1:

- OB State License Number
- 1G Provider UPIN Number
- G2 Provider Commercial Number
- LU Location Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

**DESCRIPTION:** If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.

**FIELD SPECIFICATION:** This field allows for the entry of a 2 character qualifier in the shaded area.

# **EXAMPLE:**



Version 9.0

#### **ITEM NUMBER 24J**



**TITLE:** Rendering Provider ID # [lines 1–6]

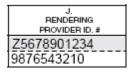
**INSTRUCTIONS:** The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Enter numbers left justified in the field.

**DESCRIPTION:** The individual performing/rendering the service should be reported in 24J and the qualifier indicating if the number is a non-NPI is reported in 24l. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.

**FIELD SPECIFICATION:** This field allows for the entry of 11 characters in the shaded area and entry of a 10-digit NPI number of the unshaded area.



# INSTRUCTIONS AND EXAMPLES OF SUPPLEMENTAL INFORMATION IN ITEM NUMBER 24

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Device Identifier of the Unique Device Identifier for supplies
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ Narrative description of unspecified code

N4 National Drug Codes (NDC)

DI Device Identifier of the Unique Device Identifier (UDI)

CTR Contract rate

JP Universal/National Tooth Designation System

JO ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

Examples: 1000.00

123.45

#### Additional Information for Reporting NDC

When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Examples: 1234.56

2

99999999.999

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

F2 International Unit ME Milligram UN Unit GR Gram ML Milliliter

When reporting compound drugs, a statement of ingredients may be required to be attached to the claim.

When required to report both the repackaged NDC and original NDC of a drug, use the shaded area of 24. Report the information in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code.

# **UDI Replacement of NDC for Supplies**

National Health Related Items Code (NHRIC) and National Drug Code (NDC) numbers assigned to some supplies/devices are being replaced with a Unique Device Identifier (UDI). When required to report a supply and that supply's NHRIC/NDC has been replaced by a UDI, report the Device Identifier (DI) portion of the UDI.

## Medical and Surgical Supplies

The following qualifiers are to be used when regulations mandate the use of the Universal Product Number (UPN) for reporting medical and surgical supplies:

EN EAN/UCC - 13 EO EAN/UCC - 8 HI HIBC (Health Care Industry Bar Code)

Supplier Labeling Standard Primary Data Message UK GTIM 14 - digit data structure UP UCC - 12

# Additional Information for Reporting Tooth Numbers and Areas of the Oral Cavity

When reporting tooth numbers, add in the following order: qualifier, tooth number, e.g., JP16. When reporting an area of the oral cavity, enter in the following order: qualifier, area of oral cavity code, e.g., JO10.

When reporting multiple tooth numbers for one procedure, add in the following order: qualifier, tooth number, blank space, tooth number, etc., e.g., JP1 16 17 32.

When reporting multiple tooth numbers for one procedure, the number of units reported in 24G is the number of teeth involved in the procedure.

When reporting multiple areas of the oral cavity for one procedure, add in the following order: qualifier, oral cavity code, blank space, oral cavity code, etc., e.g., JO10 20.

When reporting multiple areas of the oral cavity for one procedure, the number of units reported in 24G is the number of areas of the oral cavity involved in the procedure.

The following are the codes for tooth numbers, reported with the JP qualifier:

- 1 32 Permanent dentition
- 51 82 Permanent supernumerary dentition
- A T Primary dentition
- AS TS Primary supernumerary dentition

The following are the codes for areas of the oral cavity, reported with the JO qualifier:

- 00 Entire oral cavity
- 01 Maxillary arch
- 02 Mandibular arch
- 10 Upper right quadrant
- 20 Upper left quadrant
- 30 Lower left quadrant
- 40 Lower right quadrant

For further information on these codes, refer to the Current Dental Terminology (CDT) Manual available from the American Dental Association.

#### **EXAMPLES**

**Please note:** The following examples are of how to enter different types of supplemental information in 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services.

#### **UNSPECIFIED CODE:**

24. A.		ATE(S)	OF SER	VICE		B.	C.	D. PROCEDURE			E.		F.		G.	Н.	I.	J.
	From			To		PLACE OF		(Explain Unu	ısual Circu	imstances)	DIAGNOSIS				DAYS	EPSD1 Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	1	MODIFIER	POINTER		\$ CHARGES	3	DAYS OR UNITS	Plan	QUAL.	PROVIDER ID. #
ZZ Ka	aye W	alker														N	G2	12345678901
10	01	05	10	01	05	11		E1399			AB		165	00	1	Ν	NPI	0123456789

# NDC CODE:

24. A		ATE(S) C	OF SER			B.	C.	D. PROCEDURE				E.	F.		G.	H.	I.	J.
	From			To		PLACE OF		(Explain Unu	sual Circu	mstance	9S)	DIAGNOSIS			OR	EPSDT Family		RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODI	FIER	POINTER	\$ CHARGE	S	DAYS OR UNITS	Plan	QUAL.	PROVIDER ID. #
N459	N459148001665 UN1														N	G2	12345678901	
10	01	05	10	01	05	11		J0400				A	500	00	1	N	NPI	0123456789

#### **REPACKAGED NDC:**

24. A.	DA <sup>*</sup>	TE(S) O	F SERV	/ICE		B.	C.	D. PROCEDURE	S, SERVIO	CES, OR SUP	PLIES	E.	F.		_G	H.	I.	J.
	From			To		PLACE OF		(Explain Unu	sual Circu	mstances)		DIAGNOSIS			G. DAYS OR UNITS	EPSOT Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODIFIER		POINTER	\$ CHARGE	S	UNITS	Plan	QUAL.	PROVIDER ID. #
N4	55289	9047	590 J	JN30	OR	IGN4	0002	5152531								Ν	G2	12345678901
10	01	05	10	01	05	11		J3490				Α	500	00	30	N	NPI	0123456789

## **UDI REPLACEMENT OF NDC:**

24. /	A. D	ATE(S) C	OF SERV	/ICE		B.	C.	D. PROCEDURE	S, SERVIC	CES, OR	SUPPLIE	S	E.	F.		G.	H.	I.	J.
	From	1 1		To		PLACEOF		(Explain Unu	sual Circu	mstance	18)		DIAGNOSIS			DAYS OR UNITS	EPSOT Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODI	FIER		POINTER	\$ CHARGE	S	UNITS	Plan	QUAL.	PROVIDER ID. #
DI	1234	5678	9123	4567	8912	3456	7891	23456789									N	G2	12345678901
10	01	05	10	01	05	11		E0110					Α	200	00	1	N	NPI	0123456789

7/21 47

# **TOOTH NUMBER:**

24. A		ATE(S)	OF SER	VICE		B.	C.	D. PROCEDURE					E.		F.		G.	H.	I.	J.
	From	1		To		PLACE OF							DIAGNOSIS				DAYS OR UNITS	EPSD1 Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODI	FIER		POINTER	\$ CH	ARGE	S	UNITS	Plan	QUAL.	PROVIDER ID. #
JP1																		N	G2	12345678901
10	01	05	10	01	05	11		D7240					A		500	00	1	N	NPI	0123456789

# **MULTIPLE TOOTH NUMBERS:**

24. A.	D.	ATE(S)	OF SER	VICE		B.	C.	D. PROCEDURE	S, SERVIO	ES, OR	SUPPLIES	S	E.	F.		G.	Н.	I.	J.
	From			To		PLACE OF							DIAGNOSIS			DAYS	EPSDT Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODIF	IER		POINTER	\$ CHAF	GES	DAYS OR UNITS	Plan	QUAL.	PROVIDER ID. #
JP1 1	6 17 :	32															N	G2	12345678901
10	01	05	10	01	05	11		D7240					Α	50	00	4	N	NPI	0123456789

# AREA OF ORAL CAVITY:

24. A.	. D/	ATE(S)	OF SER	VICE		B.	C.	D. PROCEDURE				E.	F.		G.	H.	I.	J.
	From			To		PLACE OF		(Explain Unu	Isual Circu	mstances	S)	DIAGNOSIS			DAYS OR	EPSOT Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODIF	IER	POINTER	\$ CHARGE	S	UNITS	Plan	QUAL.	PROVIDER ID. #
JO10	)															N	G2	12345678901

# **MULTIPLE AREAS OF ORAL CAVITY:**

24. A.	D/	ATE(S)	OF SER	/ICE		B.	C.	D. PROCEDURE	S, SERVIC	CES, OR	SUPPL	JES	E.		F.		G.	H.	I.	J.
	From			To		PLACE OF		(Explain Unu	isual Circu	mstance	9S)		DIAGNOSIS				DAYS	EPSOT Family	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS		MODI	FIER		POINTER	\$ CH	ARGE	S	UNITS	Plan	QUAL.	PROVIDER ID. #
JO10	20																	Ν	G2	12345678901
10	01	05	10	01	05	11		D7310					Α		500	00	2	N	NPI	0123456789

25. FEDERAL TAX I.D. NUMBER	SSN EIN

**TITLE:** Federal Tax ID Number

**INSTRUCTIONS:** Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

**DESCRIPTION:** The "Federal Tax ID Number" is the unique identifier assigned by a federal or state agency.

**FIELD SPECIFICATION:** This field allows for the entry of 15 characters for the "Federal Tax ID Number" and 1 character in either box.

#### **EXAMPLE:**

25. FEDERAL TAX I.D. NUMBER	SSN EIN
000111222333444	$\square$ $\times$

#### **ITEM NUMBER 26**

26. PATIENT'S ACCOUNT NO.
Za PANEM GAGGGGM No.

TITLE: Patient's Account No.

**INSTRUCTIONS:** Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

**Note:** While the patient's account number is a required data element in the 837P claim transaction, it is strongly encouraged but not required on a paper claim. Payers or their vendors may choose to enter a default into the field if no number is reported by the provider for reporting in the 835 remittance. If no default number is used within the internal processing system, payers would report a single zero on an 835 remittance per the 835 TR3.

**DESCRIPTION:** The "Patient's Account No." is the identifier assigned by the provider.

**FIELD SPECIFICATION:** This field allows for the entry of 14 characters.



27. ACCEPT A	ASSI	GNMENT? see back)
YES		NO

TITLE: Accept Assignment?

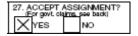
**INSTRUCTIONS:** Enter an X in the correct box. Only one box can be marked.

Report "Accept Assignment?" for all payers.

**DESCRIPTION:** The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

FIELD SPECIFICATION: This field allows for the entry of 1 character in either box.

#### **EXAMPLE:**



### **ITEM NUMBER 28**



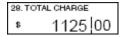
TITLE: Total Charge

**INSTRUCTIONS**: Enter total charges for the services (i.e., total of all charges in 24F).

Enter the amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**DESCRIPTION:** The "Total Charge" is the total billed amount for all services entered in 24F (lines 1–6).

**FIELD SPECIFICATION:** This field allows for the entry of 7 digits to the left of the vertical line and 2 digits to the right of the vertical line.



29. AMOUN	TPAID
29. AMOUN'	ļ

**TITLE:** Amount Paid

**INSTRUCTIONS:** Enter total amount the patient and/or other payers paid on the covered services only.

Enter the amount right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area if the amount is a whole number.

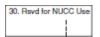
**DESCRIPTION:** The "Amount Paid" is the payment received from the patient or other payers.

**FIELD SPECIFICATION:** This field allows for the entry of 6 digits to the left of the vertical line and 2 digits to the right of the vertical line.

# **EXAMPLE:**



#### **ITEM NUMBER 30**



**TITLE:** Reserved for NUCC Use

**INSTRUCTIONS:** This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

**DESCRIPTION:** This field is reserved for NUCC use.

FIELD SPECIFICATION: None

**EXAMPLE:** None

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

**TITLE:** Signature of Physician or Supplier Including Degrees or Credentials

**INSTRUCTIONS:** "Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1.

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM|DD|YYY), 8-digit date (MM|DD|YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

**DESCRIPTION:** The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.

**FIELD SPECIFICATION:** Use the space available to enter signature and date.

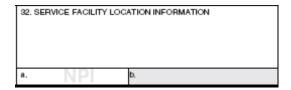
#### **EXAMPLE:**

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.)

Joe Smith MD 09/30/05

SIGNED DATE

## ITEM NUMBER 32, 32a, AND 32b



**TITLE 32:** Service Facility Location Information

**INSTRUCTIONS:** Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier.

If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.

Enter the name and address information in the following format:

1<sup>st</sup> Line – Name 2<sup>nd</sup> Line – Address 3<sup>rd</sup> Line – City. State and ZIP code

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

**DESCRIPTION:** The name and address of facility where services were rendered identifies the site where service(s) were provided.

**FIELD SPECIFICATION:** This field allows for the entry of three lines of 26 characters each in the Service Facility Location Information area.

TITLE 32a: NPI#

**INSTRUCTIONS:** Enter the NPI number of the service facility location in 32a.

Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

**DESCRIPTION:** The NPI number refers to the HIPAA National Provider Identifier number.

**FIELD SPECIFICATION:** This field allows for the entry of a 10-digit NPI number.

TITLE 32b: Other ID#

**INSTRUCTIONS:** Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

The NUCC defines the following qualifiers used in 5010A1:

OB State License Number

G2 Provider Commercial Number

LU Location Number

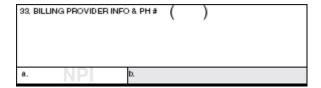
**DESCRIPTION:** The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

**FIELD SPECIFICATION:** This field allows for the entry of 14 characters in 32b.

# **EXAMPLE:**

SERVICE FACILITY LOCATION INFORMATION
 General Hospital
 9876 Hospital Street
 Anytown IL 60610-9876
 5678901234
 D. G2A1234567890

## ITEM NUMBER 33, 33a, AND 33b



TITLE 33: Billing Provider Info & Ph #

**INSTRUCTIONS:** Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

```
1<sup>st</sup> Line – Name
2<sup>nd</sup> Line – Address
3<sup>rd</sup> Line – City, State and ZIP code
```

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen. Do not use a hyphen or space as a separator within the telephone number.

If reporting a foreign address, contact payer for specific reporting instructions.

5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.

**DESCRIPTION:** The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.

**FIELD SPECIFICATION:** This field allows for the entry of the following: 3 characters for area code, 9 characters for phone number, and 3 lines of 29 characters in the Billing Provider Info area.

TITLE 33a: NPI#

**INSTRUCTIONS:** Enter the NPI number of the billing provider in 33a.

**DESCRIPTION:** The NPI number refers to the HIPAA National Provider Identifier number.

**FIELD SPECIFICATION:** This field allows for the entry of a 10-digit NPI number.

#### TITLE 33b: Other ID#

**INSTRUCTIONS:** Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

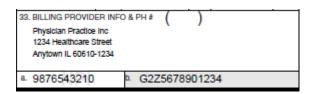
The NUCC defines the following qualifiers used in 5010A1:

- OB State License Number
- G2 Provider Commercial Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

**DESCRIPTION:** The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.

**FIELD SPECIFICATION:** This field allows for the entry of 17 characters in 33b.



# **REFERENCES**

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Health Care Claim: Professional (837), 005010X222. Washington Publishing Company, May 2006. <a href="http://www.wpcedi.com">http://www.wpcedi.com</a>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Professional (837), 005010X222A1. Washington Publishing Company, June 2010. <a href="http://www.wpcedi.com">http://www.wpcedi.com</a>.

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# **APPENDIX A: DEFINITIONS**

The following definitions apply to terms used on the 1500 Claim Form.

#### **PROVIDER TERMS**

#### **Referring Provider**

The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported.

Examples include, but are not limited to, primary care provider referring to a specialist; orthodontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency.

## **Ordering Provider**

The Ordering Provider is the individual who requested the services or items being reported on this service line.

Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.

# **Rendering Provider**

#### 5010A1 837P

The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.

#### **Future Versions of 837P**

The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, that individual is considered the Rendering Provider.

The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.

## **Supervising Provider**

The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported.

An example includes, but is not limited to, supervision of a resident physician.

#### **Purchased Service Provider**

A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who is billing for the service.

Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider.

# **INDIVIDUAL TERMS**

# **Patient**

An individual who has received, is receiving, or intends to receive health care services. (Health care services as defined by federal and state regulations.)

# Dependent

An individual who has insurance coverage under the policy of another individual.

# Subscriber

An individual or entity that is the holder of an insurance policy (including health, property and casualty, auto, workers' compensation, or other liability) for the purposes of health care services.

# Insured

An individual or entity that has insurance coverage.

# **APPENDIX B: ABBREVIATIONS**

AMA - American Medical Association

BLK Lung – Black Lung

CHAMPVA - Civilian Health and Medical Program of the Department of Veterans Affairs

CLIA – Clinical Laboratory Improvement Amendments

CMS – Centers for Medicare & Medicaid Services, formerly HCFA

COB - Coordination of Benefits

CPT® – Current Procedural Terminology, 4th Edition

DD – Day, indicates entry of two digits for the day

DME – Durable Medical Equipment

EIN – Employer Identification Number

EMG – Emergency

EPSDT – Early & Periodic Screening, Diagnosis, and Treatment

F – Female

FECA – Federal Employees' Compensation Act

GTIN - Global Trade Item Number

HCFA - Health Care Financing Administration, currently CMS

HCPCS – HCFA Common Procedural Coding System

HIBCC - Health Industry Business Communications Council

HIPAA - Health Insurance Portability and Accountability Act of 1996

HMO – Health Maintenance Organization

ICD-9-CM – Internal Classification of Disease, Revision 9, Clinical Modification

ICD-10-CM - Internal Classification of Disease, Revision 10, Clinical Modification

I.D. or ID – Identification

I.D. # or ID# – Identification Number

INFO – Information

LMP – Last Menstrual Period

M – Male

MM – Month, indicates entry of two digits for the month

NDC – National Drug Codes

No. – Number

NUCC - National Uniform Claim Committee

NUCC-DS - National Uniform Claim Committee Data Set

NPI – National Provider Identifier

OMB – Office of Management and Budget

OZ – Product number Health Care Uniform Code Council

PH # – Phone Number

QUAL. – Qualifier

REF. – Reference

SOF – Signature on File

SSN – Social Security Number

UPC - Universal Product Code

UPIN – Unique Physician Identification Number

USIN – Unique Supplier Identification Number

VP – Vendor Product Number

YY – Year, indicates entry of two digits for the year

YYYY – Year, indicates entry of four digits for the year (YYYY)

# APPENDIX C: GUIDELINES FOR MODIFYING THE 1500 (02/12) CLAIM FORM

The following are the National Uniform Claim Committee's (NUCC) recommended guidelines for making modifications to the 1500 (02/12) Claim Form.

## PRINTER-SPECIFIC/SUPPLIER-SPECIFIC INFORMATION

Any printer-specific/supplier-specific information (e.g., logo, reorder number, phone number) that is preprinted on the form must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page and any other pre-printed text in the margins. (See the instructions for the location of the carrier information within the carrier block of the form.)

# TRACKING INFORMATION ADDED BY CLEARINGHOUSES, PAYERS, OR OTHER PROCESSORS

Any tracking information (e.g., time stamp, tracking number) that is added by clearinghouses, payers, or other claims processors must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page. (See the instructions for the location of the carrier information within the carrier block of the form.)

#### **BARCODES**

Any barcodes added to the form, either pre-printed or during processing, must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page. (See the instructions for the location of the carrier information within the carrier block of the form.)

#### **ADDITIONAL DATA ELEMENTS**

The NUCC strongly discourages required or optional reporting of any data elements in addition to the data content fields on the form.

# APPENDIX D: CHANGE REQUEST FORM FOR 1500 CLAIM FORM AND INSTRUCTIONS

PLEASE REVIEW THE 1500 CLAIM FORM AND INSTRUCTIONS CRITERIA IN ITS ENTIRETY BEFORE COMPLETING THE REQUEST FORM.

Questions about the 1500 Claim Form and 1500 Reference Instruction Manual can be emailed to <a href="mailto:nuccinfo@nucc.org">nuccinfo@nucc.org</a>. The request form is not needed to ask questions.

# **1500 CLAIM FORM REQUEST CRITERIA**

The following criteria are used by the NUCC when considering requests for changes to the 1500 Claim Form.

**Note:** Revisions to the 1500 Claim Form occur infrequently (e.g., every 5 - 10 years) if at all due to the impact on the industry to implement a revised form. Requests for changes to the form will be reviewed and held until the next potential revision. In addition, form space constraints limit the ability to accommodate requests for revision.

- Data being requested has been added to the X12 Health Care Claim: Professional (837P) electronic transaction.
- The need to report the data is national and not local or state specific.
- The change to the form will not significantly impact current users.
- The request includes specific information on how the current form is negatively impacting claims processing or adjudication.
- The proposed change is within the scope of work being done to revise the form. (The NUCC may limit the scope of changes it will consider during a revision of the form, based on industry feedback of the impact of implementing the changes.)

# **1500 INSTRUCTIONS REQUEST CRITERIA**

The following criteria are used by the NUCC when considering requests for changes to the 1500 Reference Instruction Manual.

- The instruction for reporting the data aligns with data reported in the X12 Health Care Claim: Professional (837P) electronic transaction.
- The need for the instruction is national and not local or state specific.
- The change to the instructions will not significantly impact current users of the instructions.
- The request includes specific information on how the current instructions are negatively impacting claims processing or adjudication.
- The request is to clarify current instructions.

# **NUCC REVIEW OF REQUESTS**

The applicant is responsible for submitting appropriate information and documentation that demonstrates the need for the change to the 1500 form or instructions. During its review, the NUCC may, but is not required to, complete independent research, which it may share with the requester.

#### **ADDITIONAL INFORMATION**

- Updated versions of the 1500 Claim Form Reference Instruction Manual are released yearly on July 1.
- Any changes, clarifications, and errata for the instructions are posted to the NUCC website, at www.nucc.org under the 1500 Claim Form tab, with the issue and effective date of the change.
- Revision of the 1500 Claim Form is done infrequently (e.g., every 5 − 10 years) due to the impact
  on the industry to implement a revised form. Information will be posted on the NUCC website
  when the form is under review for revision.
- If a request for a change is denied, the requester may not submit a new request for the same or substantially similar change for a period of one (1) year from the date of denial.

# **INSTRUCTIONS FOR SUBMITTING REQUESTS**

- 1. After reading the 1500 Claim Form and Instructions Criteria, complete all sections of the form and be as thorough as possible explaining the request.
- Include specific information and documentation that supports the need for the change and how
  the criteria are met. Requests lacking supporting information or documentation will be
  returned to the requester and will not be reviewed by the NUCC until the necessary information
  or documentation, as the case may be, is provided.
- 3. Submit completed forms to <a href="mailto:nuccinfo@nucc.org">nuccinfo@nucc.org</a>.

# **Change Request Form for 1500 Claim Form and Instructions**

Date:	
Requester Name or Organization:	Requester Contact Information:
Is the request for a change to the form or instruction	ns?
Form Instructions	
<ul> <li>Describe the change being requested. Include inform</li> <li>Align with the X12 Health Care Claim: Profest revisions),         Or         Align with new data added to the X12 Healt transaction (Form revisions),</li> <li>Meet a national need and not local or state in Not significantly impact current users of the</li> <li>Not impact current claims processing or adjusted</li> </ul>	sional (837P) electronic transaction (instruction  h Care Claim: Professional (837P) electronic  specific need, form or instructions, or
Explain the reason for the request, such as why the onew item needs to be accommodated.	current form or instruction is inadequate or what
Provide proposed language for the instruction change	ge.