National Uniform Claim Committee

1500 Health Insurance Claim Form
Reference Instruction Manual
for Form Version 08/05

May 2014

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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 INSTRUCTIONS: 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 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.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

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 four 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.

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

FIELD SPECIFIC INSTRUCTIONS

CARRIER BLOCK

The carrier block is located in the upper center and right margin of the form. A bar code that existed on some forms in the upper left margin has been eliminated. In order to distinguish this version of the form from previous versions, the 1500 symbol and the date approved by the NUCC have been added to the top, left-hand margin.

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:

1st Line – Name
2nd Line – First line of address
3rd Line – Second line of address (if necessary)
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 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). When entering a 9-digit ZIP code, include the hyphen.

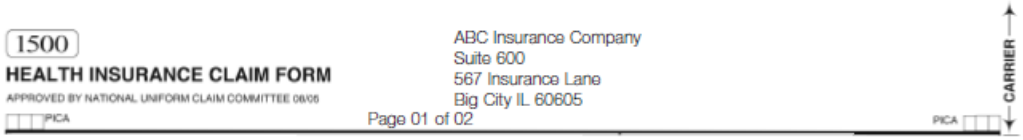
When printing page numbers on multiple page claims (generally done by clearinghouses when converting 5010A1 to the 1500 Claim Form), print the page numbers in the Carrier Block on Line 8 beginning at column 32. Page numbers are to be printed as:

Page XX of YY

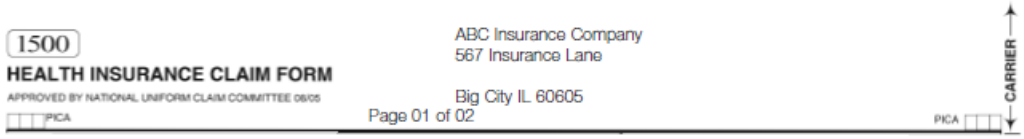
DESCRIPTION: The payer is the carrier, health plan, third-party administrator, or other payer that will handle the claim. This information directs the claim to the appropriate payer.

EXAMPLES:

Four line address:



Three line address:



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 CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (Member ID#)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)

TITLE: Medicare, Medicaid, TRICARE CHAMPUS, 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 CHAMPUS, 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 SPECIFICATIONS: This field allows for entry of 1 character in any box within the field.

EXAMPLE:

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (Member ID#)	X (SSN or ID)	☐ (SSN)	☐ (ID)

ITEM NUMBER 1a

1a. INSURED'S I.D. NUMBER	(For Program in Item 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 WORKERS COMPENSATION CLAIMS: Enter Employee ID.

FOR OTHER PROPERTY AND CASUALTY CLAIMS: Enter the Federal Tax ID or SSN 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 Item 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

ITEM NUMBER 3

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

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 characters under MM, 2 characters under DD, 4 characters under YY, and 1 character in either box.

EXAMPLE:

3. PATIENT'S BIRTH DATE MM | DD | YY SEX
01 | 01 | 1987 M ☒ F ☐

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.

EXAMPLE:

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

ITEM NUMBER 5

5. PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )

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). When entering a 9-digit ZIP code, include 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 characters for ZIP code, 3 characters for area code, and 10 characters for phone number.

EXAMPLE:

5. PATIENT'S ADDRESS (No., Street) 123 Main Street	
CITY Anytown	STATE IL
ZIP CODE 60610	TELEPHONE (Include Area Code) (312) 5551212

ITEM NUMBER 6

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.

EXAMPLE:

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☒ Other ☐

ITEM NUMBER 7

7. INSURED'S ADDRESS (No., Street)	
CITY	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). When entering a 9-digit ZIP code, include 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 characters for ZIP code, 3 characters for area code, and 10 characters for phone number.

EXAMPLE:

7. INSURED'S ADDRESS (No., Street) 123 N Main Street	
CITY Anytown	STATE IL
ZIP CODE 60610	TELEPHONE (Include Area Code) (312) 5551212

ITEM NUMBER 8

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

TITLE: Patient Status

INSTRUCTIONS: "Patient Status" does not exist in 5010A1. The NUCC recommends that this field no be used.

If required by a payer to report, enter an X in the box for the patient's marital status, and for the patient's employment or student status. Only one box on each line can be marked.

DESCRIPTION: The "Patient Status" indicates the patient's marital and employment status. "Employed" would indicate that the patient has a job. "Full-Time Student" would indicate that the patient is registered as a fulltime student as defined by the post-secondary school or university. "Part-Time Student" would indicate that the patient is registered as a part-time student as defined by the post-secondary school or university.

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

EXAMPLE:

8. PATIENT STATUS
Single [X] Married ☐ Other ☐
Employed [X] Full-Time Student ☐ Part-Time Student ☐

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 and 9a-d, 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. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

TITLE: Other Insured's Date of Birth, Sex

INSTRUCTIONS: "Other Insured's Date of Birth, Sex" does not exist in 5010A1. The NUCC recommends that this field not be used.

If required by payer to report, enter the 8-digit date of birth (MM|DD|YYYY) of the other insured and an X to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.

DESCRIPTION: The "Other Insured's Date of Birth, Sex" (gender) identifies the birth date and gender of the insured as indicated in Item Number 9.

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

EXAMPLE:

b. OTHER INSURED'S DATE OF BIRTH MM 01 DD 01 YY 1960 | SEX M ☐ F ☒

ITEM NUMBER 9c

c. EMPLOYER'S NAME OR SCHOOL NAME

TITLE: Employer's Name or School Name

INSTRUCTIONS: "Employer's Name or School Name" does not exist in 5010A1. The NUCC recommends that this field not be used.

If required by a payer to report, enter the name of the other insured's employer or school.

DESCRIPTION: The "Employer's Name or School Name" identifies the name of the employer or school attended by the other insured as indicated in Item Number 9.

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

EXAMPLE:

c. EMPLOYER'S NAME OR SCHOOL NAME
Community Hospital

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 CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

☐ YES ☐ NO

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☐ NO

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.

EXAMPLE:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

☐ YES ☒ NO

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☒ NO

c. OTHER ACCIDENT?

☐ YES ☒ NO

ITEM NUMBER 10d

10d. RESERVED FOR LOCAL USE

TITLE: Reserved for Local Use

INSTRUCTIONS: Please refer to the most current instructions from the applicable public or private payer regarding the use of this field.

When required by payers to provide a 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 www.nucc.org 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 conditions). Note: Do not use Condition Codes when submitting a revised or corrected bill.

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

EXAMPLE: None

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.

FOR WORKERS COMPENSATION AND OTHER PROPERTY & CASUALTY CLAIMS: Required if known. Enter Workers' Compensation or Property & Casualty Claim Number assigned by the payer.

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-digit 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

ITEM NUMBER 11a

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

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 characters under MM, 2 characters under DD, 4 characters under YY, and 1 character in either box.

EXAMPLE:

a. INSURED'S DATE OF BIRTH MM 01 | DD 01 | YY 1958 SEX M ☒ F ☐

ITEM NUMBER 11b

b. EMPLOYER'S NAME OR SCHOOL NAME

TITLE: Employer's Name or School Name

INSTRUCTIONS: "Employer's Name or School Name" does not exist in 5010A1. The NUCC recommends that this field not be used.

If required by payer to report, enter the name of the insured's employer or school.

DESCRIPTION: The insured's "Employer's Name or School Name" refers to the name of the employer or school attended by the insured as indicated in Item Number 1a.

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

EXAMPLE:

b. EMPLOYER'S NAME OR SCHOOL NAME
Local Company

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*, return to and complete item 9 a-d.

TITLE: Is there another Health Benefit Plan?

INSTRUCTIONS: When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a-d. 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.

EXAMPLE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
☒ YES ☐ NO *If yes*, return to and complete item 9 a-d.

ITEM NUMBER 12

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

SIGNED _____ DATE _____

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 (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

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

SIGNED _____

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:

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

SIGNED SOF

ITEMS 14–33: PHYSICIAN OR SUPPLIER INFORMATION

ITEM NUMBER 14

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

TITLE: Date of Current Illness, Injury, Pregnancy

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.

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 characters under MM, 2 characters under DD, and 4 characters under YY.

EXAMPLE:

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
09 | 30 | 2005

ITEM NUMBER 15

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

TITLE: If Patient Has Had Same or Similar Illness

INSTRUCTIONS: "If Patient Has Had Same or Similar Illness" does not exist in 5010A1. The NUCC recommends that this field not be used.

If required by payer to report, enter the first date the patient had the same or a similar illness. Enter the date in the 6-digit format (MM|DD|YY) or 8-digit format (MM|DD|YYYY). Previous pregnancies are not a similar illness. Leave blank if unknown.

DESCRIPTION: A patient having had same or similar illness would indicate that the patient had a previously related condition.

FIELD SPECIFICATION: This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, and 4 characters under YY.

EXAMPLE:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY
09 | 25 | 2005

ITEM NUMBER 16

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

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 date (MM|DD|YY) or 8-digit (MM|DD|YYYY) 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 characters under MM, 2 characters under DD, and 4 characters under YY.

EXAMPLE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
	MM	DD	YY	MM	DD	YY
FROM	09	25	2005	TO 10	28	2005

ITEM NUMBER 17

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.

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.

FIELD SPECIFICATION: This field allows for the entry of 26 characters.

EXAMPLE:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
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:

0B	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 or provider designated taxonomy code.

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.

EXAMPLE:

17a.	G2	ABC1234567890
17b.	NPI	0123456789

ITEM NUMBER 18

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

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" would refer 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 characters under MM, 2 characters under DD, and 4 characters under YY.

EXAMPLE:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
	MM	DD	YY	MM	DD	YY
FROM	09	25	2005	TO 09	28	2005

ITEM NUMBER 19

19. RESERVED FOR LOCAL USE

TITLE: Reserved for Local Use

INSTRUCTIONS: Please refer to the most current instructions from the public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number.

The NUCC defines the following qualifiers used in 5010A1:

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 type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

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

When reporting a second item of data, enter three blank spaces and then the next qualifier and number/code/information.

FOR WORKERS' COMPENSATION: Required based on Jurisdictional Workers' Compensation Guidelines.

When reporting Supplemental Claim Information, use the qualifier PWK for data, followed by the appropriate Report Type Code, the appropriate Transmission Type Code, then the Attachment Control Number. Do not enter spaces between qualifiers and data. The NUCC defines the following qualifiers used in 5010A1:

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
I5	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: PWK03AA12363545465

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

FIELD SPECIFICATION: This field allows for the entry of 83 characters.

EXAMPLE: None

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 annotated, 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.

EXAMPLE:

20. OUTSIDE LAB?	$ CHARGES
☒ YES ☐ NO	112500

ITEM NUMBER 21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

TITLE: Diagnosis or Nature of Illness or Injury

INSTRUCTIONS: Enter the codes to identify the patient's diagnosis and/or condition. List no more than four ICD-9-CM diagnosis codes. Relate lines 1, 2, 3, 4 to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this field.

When entering the code, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than three beginning characters (e.g., E codes), enter the fourth character above the period.

DESCRIPTION: 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 of 3 characters prior to the period, 1 character above the period, and 4 characters after the period in each of the four line areas.

EXAMPLE:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 998 . 59 3. V18 . 0

2. 780 . 6 4. E878 8

ITEM NUMBER 22

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.

TITLE: Medicaid 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 (e.g., code).

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: "Medicaid 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. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7	ABC1234567890

ITEM NUMBER 23

23. PRIOR AUTHORIZATION NUMBER

TITLE: Prior Authorization Number

INSTRUCTIONS: Enter any of the following: prior authorization number, referral number, mammography pre-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.

EXAMPLE:

23. PRIOR AUTHORIZATION NUMBER
1234567890A

SECTION 24

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

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 44 for further instructions and examples of how to enter supplemental information.

FIELD SPECIFICATIONS: 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

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY

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 44.

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 characters under MM, 2 characters under DD, and 2 characters under YY.

EXAMPLE:

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
09	30	05	09	30	05

ITEM NUMBER 24B

TITLE: Place of Service [lines 1–6]

INSTRUCTIONS: 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: www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.

DESCRIPTION: The "Place of Service" Code identifies the location where the service was rendered.

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

EXAMPLE:

ITEM NUMBER 24C

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.

EXAMPLE:

ITEM NUMBER 24D

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
CPT/HCPCS	MODIFIER			

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 two-digit 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.

EXAMPLE:

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
CPT/HCPCS	MODIFIER			
99241	25			

ITEM NUMBER 24E

E. DIAGNOSIS POINTER

TITLE: Diagnosis Pointer [lines 1–6]

INSTRUCTIONS: In 24E, enter the diagnosis code reference number (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 number for each service should be listed first, other applicable services should follow. The reference number(s) should be 1 – 4 or multiple numbers as applicable. ICD-9-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.

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

DESCRIPTION: The “Diagnosis Pointer” is the line number 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.

EXAMPLE:

E. DIAGNOSIS POINTER
1234

ITEM NUMBER 24F

F. $ CHARGES	

TITLE: $Charges [lines 1–6]

INSTRUCTIONS: Enter the charge for each listed service.

Enter the number 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: "$Charges" is the total billed amount for each service line.

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

EXAMPLE:

F. $ CHARGES	
50	00

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.

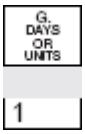
Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

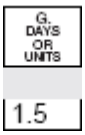
Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management").

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 characters in the unshaded area.

EXAMPLES:





ITEM NUMBER 24H

TITLE: EPSDT/Family Plan [lines 1–6]

INSTRUCTIONS: For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:

If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only.

If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is 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.)

If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.

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.

EXAMPLE:

ITEM NUMBER 24I

I. ID. QUAL.
NPI
NPI
NPI
NPI
NPI
NPI

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:

0B	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 type, classification, and/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:

I. ID. QUAL.
G2
NPI

ITEM NUMBER 24J

J. RENDERING PROVIDER ID. #

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

INSTRUCTIONS: The individual rendering the service should be 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 24I. 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.

EXAMPLE:

J. RENDERING PROVIDER ID. #
Z5678901234
9876543210

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
- Vendor Product Number – Health Industry Business Communications Council (HIBCC) (Reporting Vendor Product Number does not exist in 5010A1. The NUCC recommends that this not be reported.)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products (Reporting Product Number does not exist in 5010A1. The NUCC recommends that this not be reported.)
- 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)
VP	Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard (Reporting Vendor Product Number does not exist in 5010A1. The NUCC recommends that this not be reported.)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) (Reporting Product Number does not exist in 5010A1. The NUCC recommends that this not be reported.)
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

<u>Additional Information for Reporting NDC</u>

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.

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

<u>Additional Information for Reporting Tooth Numbers and Areas of the Oral Cavity</u>
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, 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. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker																	N	G2	12345678901
10	01	05	10	01	05	11		E1399					12	165	00	1	N	NPI	0123456789

NDC CODE:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1																	N	G2	12345678901
10	01	05	10	01	05	11		J0400					1	250	00	40	N	NPI	0123456789

TOOTH NUMBER:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JP1																	N	G2	12345678901
10	01	05	10	01	05	11		D7240					1	500	00	1	N	NPI	0123456789

MULTIPLE TOOTH NUMBERS:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JP1 16 17 32																	N	G2	12345678901
10	01	05	10	01	05	11		D7240					1	500	00	4	N	NPI	0123456789

AREA OF ORAL CAVITY:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JO10																	N	G2	12345678901
10	01	05	10	01	05	11		41820					1	500	00	1	N	NPI	0123456789

MULTIPLE AREAS OF ORAL CAVITY:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
JO10 20																	N	G2	12345678901
10	01	05	10	01	05	11		D7310					1	500	00	2	N	NPI	0123456789

ITEM NUMBER 25

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
	☐	☒

ITEM NUMBER 26

26. PATIENT'S ACCOUNT 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.

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

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

EXAMPLE:

26. PATIENT'S ACCOUNT NO.
12341234

ITEM NUMBER 27

27. ACCEPT ASSIGNMENT?
(For govt. claims, 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:

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

ITEM NUMBER 28

28. TOTAL CHARGE
$

TITLE: Total Charge

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

Enter the number 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 characters to the left of the vertical line and 2 characters to the right of the vertical line.

EXAMPLE:

28. TOTAL CHARGE
$ 1125|00

ITEM NUMBER 29

29. AMOUNT PAID
$

TITLE: Amount Paid

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

Enter the number 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 "Amount Paid" is the payment received from the patient or other payers.

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

EXAMPLE:

29. AMOUNT PAID
$ 10|00

ITEM NUMBER 30

30. BALANCE DUE
$

TITLE: Balance Due

INSTRUCTIONS: "Balance Due" does not exist in 5010A1. The NUCC recommends that this field not be used.

If required by a payer to report, enter total amount due.

Enter number 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.

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

EXAMPLE:

30. BALANCE DUE
$ 1115|00

ITEM NUMBER 31

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|YY), 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

32. SERVICE FACILITY LOCATION INFORMATION	
a. NPI	b.

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:

1st Line – Name
2nd Line – Address
3rd 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, including 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 10 characters.

TITLE 32B: Other ID#

INSTRUCTIONS: Enter the 2-digit 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:

0B	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:

32. SERVICE FACILITY LOCATION INFORMATION General Hospital 9876 Hospital Street Anytown IL 60610-9876	
a. 5678901234	b. G2A1234567890

ITEM NUMBER 33, 33A, AND 33B

33. BILLING PROVIDER INFO & PH # ( )	
a. NPI	b.

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:

1st Line – Name
2nd Line – Address
3rd 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, including 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 87 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 10 characters.

TITLE 33B: Other ID#

INSTRUCTIONS: Enter the 2-digit 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:

0B	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 type, classification, and/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.

EXAMPLE:

33. BILLING PROVIDER INFO & PH # ( )	
Physician Practice Inc 1234 Healthcare Street Anytown IL 60610-1234	
a. 9876543210	b. G2Z5678901234

REFERENCES

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Health Care Claim: Professional (837), 005010X222. Washington Publishing Company, May 2006. <http:www.wpc-edi.com>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Professional (837), 005010X222A1. Washington Publishing Company, June 2010. <http:www.wpc-edi.com>.

APPENDIX A: PROVIDER DEFINITIONS

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

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
5010 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.

APPENDIX B: ABBREVIATIONS

AMA – American Medical Association

BLK Lung – Black Lung

CHAMPUS – Civilian Health and Medical Program of the Uniformed Services

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 (08/05) CLAIM FORM

The following are the National Uniform Claim Committee's (NUCC) recommended guidelines for making modifications to the 1500 (08/05) 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: MAINTENANCE OF THE 1500 REFERENCE INSTRUCTION MANUAL

VERSION RELEASES

Updated versions of the 1500 Claim Form Reference Instruction Manual will be released yearly on July 1.

Any changes, clarifications, or errata will be listed on the NUCC website, at www.nucc.org under the 1500 Claim Form tab, with the issue and effective date of the change.

MAINTENANCE PROCESS

1. Requests for clarifications or changes to the 1500 Instruction Manual should be submitted by completing the 1500 Claim Form Instructions Change Request Form (see Attachment 1 to Appendix D). The request/form can then be emailed to the NUCC at: info@nucc.org.

2. The Data/1500 Subcommittee will review the requests for changes or clarifications to the 1500 Instruction Manual. The subcommittee's review may include any of the following:
    - coordinating the request with requirements outlined in the ASC X12 Health Care Claim: Professional (837) Technical Report Type 3 adopted under HIPAA,
    - gaining a wider understanding of the industry's need related to the request,
    - gathering additional data, when necessary, on the overall impact of the request, and/or
    - balancing the needs of the requester versus the industry

3. The Data/1500 Subcommittee will develop a recommended response and, when appropriate, any corresponding changes to the Instruction Manual.

4. The NUCC will review the request and recommendation made by the Data/1500 Subcommittee.

5. The NUCC will make the final decision in response to the request.

6. The requester will be notified of the NUCC's final decision.

7. Final decisions may be appealed by the requester resubmitting the request along with additional supporting information.

8. If changes and/or clarifications are made to the instructions as a result of the final decision, they will be included on the NUCC's website under the 1500 Claim Form tab with the listing of changes, clarifications, and/or errata.

9. All changes, clarifications, and edits from the previous release will be incorporated into the Instruction Manual for the yearly release on July 1.

ATTACHMENT 1 TO APPENDIX D – 1500 CLAIM FORM INSTRUCTIONS CHANGE REQUEST FORM

1500 Claim Form Instruction Change Request
(Provide requested information / Mark applicable box)

Date:	

1. Requester Information

Individual's Name:			
Address (Line 1):			
Address (Line 2):			
City:			
State:		Zip Code	
Telephone:			
Fax:			
E-mail:			

2. Does this request and information provided represent the official position of a particular health care organization or a third-party payer/administrator?

Yes:		No:	
If Yes, please provide Organization / Entity Name:			

3. Is this request for an instruction revision or deletion?

Revision:		Deletion:	
Go to Question 4		Go to Question 8	

4. Specify current 1500 claim form Item # to be REVISED.	Item #		Page	

5. Description of proposed revision

Check here ___ if continued on a separate sheet

6. Reason for proposed revision, including reasons why the existing instruction is inadequate.

Check here ___ if continued on a separate sheet

7. Proposed revised instruction (text additions underlined in blue; text deletions ~~stricken through in red~~).

Check here ___ if continued on a separate sheet

8. Specify current 1500 claim form Item # to be DELETED.	Item #		Page	

9. Reason for Proposed deletion, including reasons why the existing instruction is no longer appropriate.

Check here ___ if continued on a separate sheet

Questions 10 through 12 apply to requests for revision or deletion.

10. Is there supporting documentation or literature that you wish to submit?

Yes:		No:	

11. If Yes, please note how material will be submitted.

"Fax":		Surface Mail:		E-Mail:	

12. Additional Comments:

Check here ___ if continued on a separate sheet