

CMS-1500 Completion Guide

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> PICA			PICA <input type="checkbox"/> <input type="checkbox"/>		
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
CITY			6. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		
ZIP CODE			TELEPHONE (Include Area Code) () ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____		
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE		
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.			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 _____			SIGNED _____		
DATE _____			DATE _____		

CARRIER

PATIENT AND INSURED INFORMATION

#	FIELD NAME	FIELD INSTRUCTIONS
1	Health Insurance Coverage	Check the type coverage applicable to this claim.
1a	Insured's ID Number	Print insured's Medicaid ID number.
2	Patient's Name, Address, City, State, Zip	Print insured's name and address.
3	Patient's Date of Birth	Print insured's date of birth.
6	Patient's Status	Check the appropriate box for patient's marital status.
9	Other Insured's Name	Enter the name of the insured.

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PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 9a		b. IS PATIENT'S CONDITION RELATED TO: 10. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> 9b		c. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME 9c		d. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10c	
d. INSURANCE PLAN NAME OR PROGRAM NAME 9d		10d. RESERVED FOR LOCAL USE	
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.		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
SIGNED _____ DATE _____		b. EMPLOYER'S NAME OR SCHOOL NAME	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
		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 _____	

CARRIER

PATIENT AND INSURED INFORMATION

#	FIELD NAME	FIELD INSTRUCTIONS
9a	Other Insured's Policy or Group Number	Enter the policy number.
9c	Employer's Name or School Name	Enter the amount paid by other insurance. If the insurance has denied, enter "0.00".
9d	Insurance Plan Name or Program Name	Enter the three-digit carrier code of the other insurance.
10	Is Patient's Condition Related to:	Check "Yes" or "No".
		10a Employment?
		10b Auto Accident?
		10c Other Accident?

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PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
CITY STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
ZIP CODE TELEPHONE (Include Area Code) ()		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code) ()		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER 11	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME 11b	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME 11c	
10d. RESERVED FOR LOCAL USE 10d		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
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. 12 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 _____	

CARRIER
PATIENT AND INSURED INFORMATION

#	FIELD NAME	FIELD INSTRUCTIONS
10d	Reserved for Local Use	Enter the appropriate TPL indicator.
11	Insured's Policy Group or FECA Number	Enter the policy number.
11b	Employer's Name or School Name	Enter the amount paid by other insurance. If the insurance has denied, enter "0.00".
11c	Insurance Plan Name or Program Name	Enter the three-digit carrier code of the other insurance.
11d	Is There Another Health Insurance?	Check "Yes" or "No".
12	Patient's or Authorized Person's Signature	Enter "Signature on File" or patient's signature.

CMS-1500 Completion Guide

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 FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.	17b.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER						23	
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. #
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.)				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()	
SIGNED _____ DATE _____				a. NPI b.		a. NPI b.	

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

#	FIELD NAME	FIELD INSTRUCTIONS
17	Name of Referring Provider or Other Source	Enter the name of the referring physician.
		17a Not applicable.
		17b Not applicable.
19	Reserved for Local Use	Enter the referral number for beneficiaries in special programs, if applicable.
21	Diagnosis or Nature of Illness or Injury	Enter the diagnosis code.
23	Prior Authorization	Enter the prior authorization number for this claim, if applicable.

CMS-1500 Completion Guide

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE				17b. NPI _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
1. _____ 3. _____						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) CPCS MODIFIER		E. DIAGNOSIS POINTER	24f 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) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()			
SIGNED		DATE		a. NPI		b. NPI		a. NPI		b. NPI	

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#	FIELD NAME		FIELD INSTRUCTIONS
24a	Date(s) of Service	Shaded	Enter the 11-digit NDC with no hyphens.
		Unshaded	Enter the date of service for each procedure, service, or supply.
24b	Place of Service	Unshaded	Enter the two-character place of service code.
24c	EMG	Unshaded	Enter "Y", if services were rendered on an emergency basis.
24d	Procedures, Services, or Supplies	Unshaded	Enter procedure code and, if applicable, two-digit modifier.
24e	Diagnosis Pointer	Unshaded	Not applicable.
24f	Charges	Unshaded	Enter the charge amount for the service.

CMS-1500 Completion Guide

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. RESERVED FOR LOCAL USE						17b. NPI _____			20. OUTSIDE LAB? \$ CHARGES						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						22. MEDICAID RESUBMISSION CODE			ORIGINAL REF. NO.						
1. _____ 3. _____						23. PRIOR AUTHORIZATION NUMBER									
2. _____ 4. _____															
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. Pen	I. 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)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
25								\$		\$		\$			
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()							
SIGNED				DATE				a. NPI		b.		a. NPI		b.	

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#	FIELD NAME		FIELD INSTRUCTIONS
24g	Days or Units	Unshaded	Enter the days or units provided for the procedure.
24h	ESPDT Family Plan	Unshaded	Enter "Y", if claim is for ESPDT services or a referral from an ESPDT Screening.
24i	ID Qualifier	Shaded	Enter the ID Qualifier. *ID Qualifiers: Use 1D with Medicaid Provider ID or ZZ with taxonomy code.
24j	Rendering ID #	Shaded	Enter the Medicaid Provider ID or the taxonomy code.
		Unshaded	Typical Providers, enter the NPI.
25	Federal Tax ID Number		Enter the provider's federal tax ID number.

CMS-1500 Completion Guide

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
17b. NPI _____						19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES		
<input type="checkbox"/> YES <input type="checkbox"/> NO						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		
1. _____ 3. _____						2. _____ 4. _____						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. (26)			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) (27)			28. TOTAL CHARGE \$ (28)		29. AMOUNT PAID \$ (29)	30. BALANCE DUE \$ (30)
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.) (31)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILL TO PROVIDER INFO & PH. ()		
SIGNED _____ DATE _____						a. NPI			b. _____			a. NPI		b. _____

NUCC Instruction Manual available at: www.nucc.org

#	FIELD NAME	FIELD INSTRUCTIONS
26	Patient Account No.	Enter the patient's account number.
27	Accept Assignment	Check "Yes" or "No" to accept assignment.
28	Total Charge	Enter the total charge for the services listed.
29	Amount Paid	Enter the total amount paid from all insurance sources.
30	Balance Due	Enter the balance due from Medicaid. When a beneficiary has third party coverage, including Medicare, this is the patient responsibility amount. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept in full from the third party payer, including Medicare.
31	Signature of Physician or Supplier	Not applicable.

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. RESERVED FOR LOCAL USE			17b. NPI	20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		
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) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$
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.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____		a. 32a	b. 32b	a. 33a	b. 33b	

NUCC Instruction Manual available at: www.nucc.org

#	FIELD NAME	FIELD INSTRUCTIONS
32	Service Facility Location Information	Enter the address where services were rendered. Include zip code + 4. *Use this field if different from the "pay to" address in Field 33.
		32a Typical Providers, enter the NPI.
		32b Enter the ID Qualifier and the Medicaid Provider ID or taxonomy code. *ID Qualifiers: Use 1D with Medicaid Provider ID or ZZ with taxonomy code (no spaces).
33	Billing Provider INFO & Phone #	Enter the billing provider's name, address, and phone number. Include zip code + 4.
		33a Typical Providers, enter the NPI.
		33b Enter the ID Qualifier and the Medicaid ID number or taxonomy code. *ID Qualifiers: Use 1D with Medicaid Provider ID or ZZ with taxonomy code (no spaces).

*Typical Providers: Enter ID Qualifier ZZ with taxonomy code.

*Atypical Providers: Enter ID Qualifier 1D with Medicaid Provider ID.