

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"/> (Medicare #)			1. MEDICARE <input type="checkbox"/> (Medicare #)	1a. INSURED'S I.D. NUMBER <input type="checkbox"/> (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE (MM DD YY)	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street)	
CITY STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) 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"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. EMPLOYER'S NAME OR SCHOOL NAME	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>			c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME			10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, return to and complete item 9 a-d.</i>	
d. INSURANCE PLAN NAME OR PROGRAM NAME			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 _____	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			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.

CMS-1500 Completion Guide

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA							PICA <input type="checkbox"/> <input type="checkbox"/> <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"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)									6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)											
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>														
ZIP CODE			TELEPHONE (Include Area Code) ()						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			CITY			STATE											
ZIP CODE			TELEPHONE (Include Area Code) ()						9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:														
9a. OTHER INSURED'S POLICY OR GROUP NUMBER									10a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									11. INSURED'S POLICY GROUP OR FECA NUMBER								
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY									10b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)									a. INSURED'S DATE OF BIRTH MM DD YY								
9c. EMPLOYER'S NAME OR SCHOOL NAME									10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									b. EMPLOYER'S NAME OR SCHOOL NAME								
9d. INSURANCE PLAN NAME OR PROGRAM NAME									10d. RESERVED FOR LOCAL USE									c. INSURANCE PLAN NAME OR PROGRAM NAME								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																		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.												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 _____ DATE _____												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?

CMS-1500 Completion Guide

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA						PICA					
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>						1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)						4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
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"/>					
7. INSURED'S ADDRESS (No., Street)						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					
CITY STATE						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:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE <input type="checkbox"/> (10d)					
11. INSURED'S POLICY GROUP OR FECA NUMBER (11)						a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. EMPLOYER'S NAME OR SCHOOL NAME (11b)						b. EMPLOYER'S NAME OR SCHOOL NAME					
c. INSURANCE PLAN NAME OR PROGRAM NAME (11c)						c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
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)						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 _____ DATE _____						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 gov. 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

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

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		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.	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. _____ 24a. _____ 24b. _____ 24c. _____ 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) 24d. PCS MODIFIER		E. DIAGNOSIS POINTER
						F. \$ CHARGES 24f
						G. DAYS OR UNITS
						H. EPSDT Family Plan
						I. ID. QUAL.
						J. RENDERING PROVIDER ID. #
						NPI
						NPI
						NPI
						NPI
						NPI
						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.) SIGNED _____ DATE _____			32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____		33. BILLING PROVIDER INFO & PH # () a. NPI b. _____	

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

#	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

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. _____			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. Plan	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						<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$		\$	
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. _____

NUCC Instruction Manual available at: www.nucc.org

#	FIELD NAME		FIELD INSTRUCTIONS
24g	Days or Units	Unshaded	Enter the days or units provided for the procedure.
24h	EPSDT 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.

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

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

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. _____			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								
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						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 govt. 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 () (30)								
SIGNED						DATE						a. NPI			b. NPI					

PHYSICIAN OR SUPPLIER INFORMATION

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.
31	Signature of Physician or Supplier	Not applicable.

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. _____			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							
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. 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. 32a NPI _____ b. 32b _____					a. 33a NPI _____ 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.