PROVIDER Bulletin

November 21, 2018

This Provider Bulletin applies to the lines of business and provider types checked below:

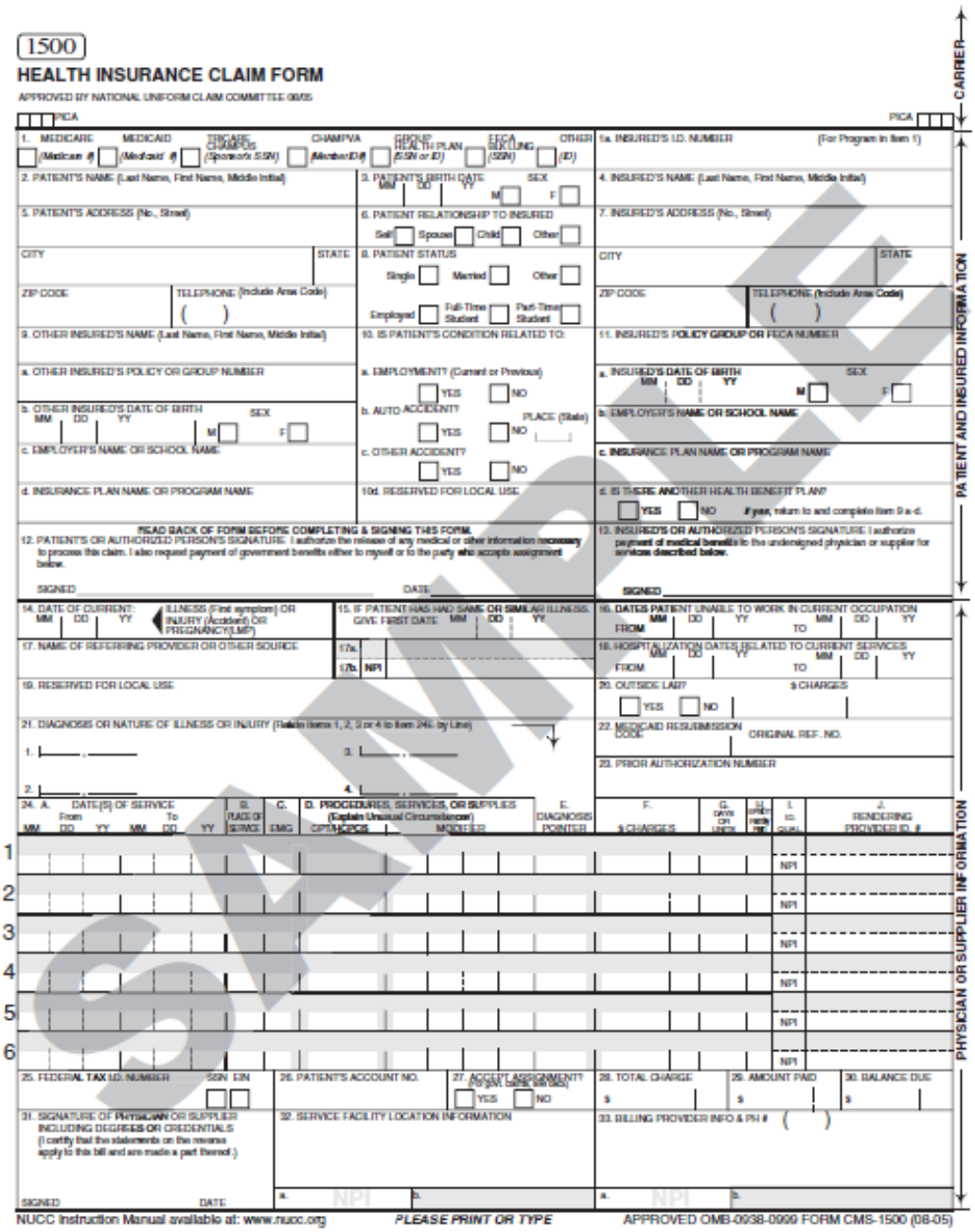
☒ **PHP (Medicare)** ☒ **Primary Care Physicians** ☒ **Specialists**

☒ **PHC (Medicaid)** ☐ **Ancillary** ☐ **Hospitals**

CMS 1500 Claim Submission Guide

The Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee have approved the CMS 1500 claim form for professional paper and electronic billing. The CMS 1500 claim form accommodates the National Provider Identifier (NPI) and ICD-10 coding. Sample CMS 1500 forms for professional claims is provided below.

If you have any questions regarding the UB-04 claim form, please call our Claims Customer Service at 855.318.4387.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

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 SEX

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

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

6. PATIENT RELATIONSHIP TO INSURED

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

CITY STATE

8. PATIENT STATUS

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)

a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH SEX

b. AUTO ACCIDENT? PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?

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?

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To	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

SAMPLE

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

For Centers for Medicare & Medicaid Services (CMS) 1500 Clams Form

Description	Required	Situational
Field 1: type of claim	X	
Field 1a: insured identification number	X	
Field 2: patient name	X	
Field 3: patient birth date/sex	X	
Field 4: insured name ("Same" or leaving blank is **not** acceptable.)		X
Field 5: patient address	X	
Field 6: relationship of patient to insured	X	
Field 7: insured address	X	
Field 8: patient status (required only if patient is a dependent)		X
Field 9: other insurance (only if 11d is answered in the affirmative); leave blank if no other insurance ("NA" or "none" is **not** acceptable)		X
Field 10a, b, c: relation of condition to employment or auto accident		X
Field 11: policy number (situational in IG)	X	
Field 11c: name of plan (situational in IG)	X	
Field 11d: other insurance (if applicable)	X	
Field 12: information release ("signature on file" is acceptable)		X
Field 13: assignment of benefits (Indicate "Y" or "N"; **do not** leave blank.)	X	
Field 14: date of onset of illness or condition		X
Field 15: patient sex		X
Field 16: marital status (not used in EDI)		X
Field 17a: NPI # of referring provider (situational)	X	
Field 18: hour of admission	X	

This Provider Bulletin is not intended to replace or conflict with any requirements outlined in your signed Agreement with AHF, PHP or PHC. If you have any questions or suggestions contact the Provider Relations Department at 954.522.3132 or email to remon.walker@phcplans.org

Field 19- qualifier "ZZ" followed by Provider Taxonomy Code (Billing or Rendering Provider) Optional entry	X	
Field 20: admission source code	X	
Field 21: diagnosis	X	
Field 22: patient status-at-discharge code		X
Field 23: prior authorization number (if any)	X	
Field 24: A, B, C, D, E, F, G, H, I services and diagnoses	X	
Field 24j: NPI # of rendering/performing provider	X	
Field 25: federal tax ID number	X	
Field 28: total charge	X	
Field 29: Amount Paid	X	
Field 30: Balance Due	X	
Field 31: signature of provider (provider name sufficient)	X	
Field 32: address of facility where services were rendered	X	
Field 32b: NPI # for Facility location for where services were rendered	X	
Field 33: provider's billing information	X	
Field 33b: NPI for the Billing/Pay to provider	X	

To expedite claims processing & payment, we encourage all providers to submit claims electronically to PHC/PHP via Change Healthcare, Payor ID: 95411

Paper Claims: Attn: Claims
PHP/PHC
P.O. Box 7490
LaVerne, CA 91750

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