HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse R Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE NR

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

PATIENT AND INSURED INFORMATION

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER R

a. OTHER INSURED'S POLICY OR GROUP NUMBER S

a. EMPLOYMENT? (Current or Previous) YES S NO

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

b. RESERVED FOR NUCC USE NR

b. AUTO ACCIDENT? YES S NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC) NR

c. RESERVED FOR NUCC USE NR

c. OTHER ACCIDENT? YES S NO

c. INSURANCE PLAN NAME OR PROGRAM NAME R

d. INSURANCE PLAN NAME OR PROGRAM NAME S

10d. CLAIM CODES (Designated by NUCC) NR

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

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. NR

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. NR

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD R QUAL.

15. OTHER DATE QUAL. S MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE S

17a. NR

17b. NPI S

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NR

20. OUTSIDE LAB? YES NO R $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) R ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE NR ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER NR

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 R	R	S	R	S	R	R	R	S	NR NPI	NR R
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER R SSN EIN

26. PATIENT'S ACCOUNT NO. S

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

28. TOTAL CHARGE $ R

29. AMOUNT PAID $ S

30. Rsvd for NUCC Use NR

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.) R

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION S

a. S NPI b. NR

33. BILLING PROVIDER INFO & PH # ( ) R

a. R NPI b. NR

SAMPLE

KEY

- R REQUIRED
- S SITUATIONAL --- ONLY IF APPROPRIATE TO THIS CLAIM
- NR NOT REQUIRED/NOT USED

1. TYPE OF HEALTH INSURANCE COVERAGE R
Select "Other"

1A. INSURED ID NUMBER R
Enter the subscriber's identification number

2. PATIENT'S NAME R Last name, First name, Middle initial
Enter the patient's last name, first name and middle initial.

3. PATIENT'S BIRTH DATE/SEX R
Enter the patient's date of birth using the eight-digit date format (MM/DD/CCYY).
Next, select the patient's gender.

4. INSURED'S NAME R Last name, First name, Middle initial
Enter the insured's last name, first name and middle initial.

5. PATIENT'S ADDRESS/TELEPHONE NUMBER R
Enter the patient's permanent mailing address and telephone number.

6. PATIENT'S RELATIONSHIP TO THE INSURED R
Select the appropriate box for patient's relationship to the insured person.

7. INSURED'S ADDRESS/TELEPHONE NUMBER S
Enter the insured person's permanent mailing address (complete if different from the patient's address)

8. RESERVED FOR NUCC USE NR

9. OTHER INSURED'S NAME S
Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.

9A. OTHER INSURED'S POLICY OR GROUP NUMBER S
Enter the other insured person's policy or group number.

9B. RESERVED FOR NUCC USE NR
Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY).

9C. RESERVED FOR NUCC USE NR
Enter the other insured person's employer or school name.

9D. INSURANCE PLAN NAME OR PROGRAM NAME S
Enter the name of the other insured person's insurance plan or program name.

10A-D. IS PATIENT'S CONDITION RELATED TO:
For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.

10A. Select whether the patient's condition is related to employment. S

10B. Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation, i.e. IL. S

10C. Select whether the patient's condition is related to any other type of accident. S

10D. CLAIM CODES (DESIGNATED BY NUCC) NR

11. INSURED'S POLICY GROUP OR FECA NUMBER
Enter the subscriber's ID number again.

11A. INSURED'S DATE OF BIRTH, SEX R
Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.

11B. OTHER CLAIM ID (DESIGNATED BY NUCC) NR
Enter the subscriber's employer or school name.

11C. INSURANCE PLAN NAME OR PROGRAM NAME R
Enter the subscriber's insurance plan name (PCU or RMA or UC)

11D. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN R
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE NR

13. INSURED OR AUTHORIZED PERSON'S SIGNATURE NR

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) R
Enter the date using an eight-digit date format (MM/DD/CCYY).

15. OTHER DATE S
Enter the date using an eight-digit date format (MM/DD/CCYY).

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S
Enter the date using an eight-digit date format (MM/DD/CCYY).

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE S
Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required only if there is a referring, ordering or supervising provider.

17A. OTHER ID# NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

17B. NPI # S
Enter the 10-digit NPI number of the referring, ordering or supervising provider.

18. HOSPITAL DATES RELATED TO CURRENT SERVICES S
Enter the hospital dates using an eight-digit date format (MM/DD/CCYY).

19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC) NR

20. OUTSIDE LAB/CHARGES R
Select "Yes" or "No" to indicate if the claim includes charges for lab services performed outside of the physician's office. If "Yes," enter the total charges.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R
Enter the ICD-9-CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional ICD-9-CM codes can be entered.

22. RESUBMISSION NR

23. PRIOR AUTHORIZATION NUMBER NR

24. SHADED AREA – SUPPLEMENTAL INFORMATION –
The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee's website at www.nucc.org.

24A. DATE(S) OF SERVICE R
Enter the dates of service using an eight-digit date format (MM/DD/CCYY).

24B. PLACE OF SERVICE R
Enter the appropriate two-digit Place of Service code.

24C. EMG S
If this service was an emergency, enter "Y" for "Yes," or leave blank if "No".

24D. PROCEDURES, SERVICES, OR SUPPLIES R
Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable.

24E. DIAGNOSIS POINTER R
Enter the appropriate ICD-9-CM diagnosis code or codes for each procedure performed. Enter one code per line of service.

24F. CHARGES R
Enter the charge for each line of service. Do not include discounts.

24G. DAYS OR UNITS R
Enter the number of days or units for each line of service.

24H. EPSDT/FAMILY PLAN S
If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code.

24I. ID QUALIFIER - SHADED FIELD NR
Not required, reserved for taxonomy code qualifier, "ZZ."

24J. RENDERING PROVIDER ID. #
SHADED FIELD NR
Not required, reserved for taxonomy code.

NON-SHADED FIELD R
Enter the performing provider's 10-digit NPI number in the non-shaded area.

25. FEDERAL TAX ID NUMBER R
Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.

26. PATIENT ACCOUNT NUMBER S
Enter account number assigned to the patient, if applicable.

27. ACCEPT ASSIGNMENT R
Select "Yes" if the provider should be paid, or select "No" if the patient should be paid.

28. TOTAL CHARGE R
Enter the total charge for all services (total of all charges in 24f).

29. AMOUNT PAID S
Enter any amount paid by the patient only. Do not enter any amount by Medicare or other insurance.

30. RSVD FOR NUCC USE NR
Enter the difference, if any, between the total charge and the amount paid.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS R
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY).

32. SERVICE FACILITY LOCATION INFORMATION S
Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.

Note: Per the NUCC Instruction Manual, Field 32 is required if Field 20 is checked "yes."
For more information, see the National Uniform Claim Committee's website at www.nucc.org.

32A. NPI S
Enter the 10-digit NPI number of the service facility location.

32B. OTHER ID# NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

33. BILLING PROVIDER INFO AND PH# R
Enter the information of the billing provider or supplier to be paid for services.

33A. NPI R
Enter the 10-digit NPI number of the billing provider.

33B. OTHER ID # NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

Note: For more information on Place of Service Codes, see the National Uniform Claim Committee's website at www.nucc.org.

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
- 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)

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

For additional information for reporting NDC units, see the National Uniform Claim Committee's website at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, ZIP code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in the BCBSIL's system just the way they leave your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

To obtain more information on electronic claim filing, call 800-746-4614 or log on to bcbsil.com.