The Plans' Supplement to the NUCC 1500 Claim Form

Reference Instruction Manual

With instructions for billing the 1500 version 02/12 form.

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1500 Claim Form—Appendix to NUCC Guide

This is an addendum to the *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual* Our guide provides specific instructions to help you complete the NUCC 1500 claim form accurately for submission to the Plans. Please note that these instructions apply to claims for Federal Employee Program (FEP) members as well. Below we list the 1500 Item Numbers in numerical order for those fields or items on the NUCC 1500 Claim Form that we require for claims processing, those that we do not require, and items for which we require different or additional information from the NUCC 1500 manual. Please note that if you submit information that is *not* required, it could delay the processing of your claim. If, after reading this guide, you have any questions, please call your Network Management and Credentialing Services at **1-800-316-BLUE (2583)**.

For 1500 Item Number:	See NUCC 1500 Manual Page #:	Item Name:	Our Requirements Clarified:
1	9	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Not required.
1a	9	Insured's ID Number	Required. Enter the subscriber's identification number exactly as it appears on their Blue Cross Blue Shield ID card, including the appropriate alpha prefix. The Member's SSN is never used as the Insured's ID number.
2	10	Patient's Name (Last Name, First Name, Middle Initial)	Required. Do not use suffixes (e.g., Jr., Sr.).
3	10	Patient's Birth Date, Sex	Required. A six or eight-digit format is accepted, i.e., MMDDYY or MMDDCCYY.
4	11	Insured's Name	Required. Enter as Last Name, First Name and Middle Initial; e.g. Smith, John A.
5	12	Patient's Address (No., Street)	Required. We require and will only accept a five-digit zip code.
6	13	Patient Relationship to Insured	Required.
7	14	Insured's Address (No., Street)	Required. Do not enter a phone number. In addition, we require and will only accept a five-digit zip code.
8	15	Reserved for NUCC use	Not required.
9	15	Other Insured's Name	Required only if 11d is "yes."

For 1500 Item Number:	See NUCC 1500 Manual Page #:	Item Name:	Our Requirements Clarified:
9a	16	Other Insured's Policy or Group Number	Required only if 11d is "yes."
9b	16	Reserved for NUCC use	Not required.
9c	17	Reserved for NUCC use	Not required.
9d	17	Insurance Plan Name or Program Name	Complete if information is known.
11c	21	Insurance Plan Name or Program Name	Not required.
11d	21	Is there another Health Benefit Plan?	Required.
12	22	Patient's or Authorized Person's Signature	Not required if you are a participating Plan Provider.
13	22	Insured's or Authorized Person's Signature	Not required if you are a participating Plan Provider.
14	23	Date of Current Illness or Injury or Pregnancy. Added QUAL to accommodate 3-byte qual.	Required. If the information is not available, please enter "N/A" for not available. Enter applicable qualifier to identify which date is being reported. Refer to NUCC manual for values.
15	23	Other Date Added QUAL to accommodate 3-byte qual.	Not required, but complete if information is known. While not required, the information will help to expedite the processing of your claim. If the information is not available, please enter "N/A" for not available. Enter applicable qualifier to identify which date is being reported. Refer to NUCC manual for values.
16	25	Dates Patient Unable to Work in Current Occupation	Not required.

For 1500 Item Number:	See NUCC 1500 Manual Page #:	Item Name:	Our Requirements Clarified:
17I	26	Name of Referring Provider or Other Source	• Not required, but please fill in when applicable to expedite the processing of your claim. If the information is not available, please enter "N/A" for not available. • Required for Independent Clinical Labs and Durable Medical Equipment (DME) providers. • Enter applicable qualifier to identify which date is being reported. Refer to NUCC manual for values.
17a	27	Other ID#	Not required.
17b	27	National Provider Identifier (NPI)	• Not required. • Required for Independent Clinical Labs and Durable Medical Equipment (DME) providers
18	28	Hospitalization Dates Related to Current Services	Required for inpatient services only.
19	29	Additional claim information (designated by NUCC)	Not required. Please enter Facility ID in Item 32B.
20	31	Outside Lab Charges	Not required.
21	3	Diagnosis or Nature of Illness or Injury (relate items A thru L to 24E by line)	Required. Please submit valid codes only.
21	3	ICD IND	Enter the applicable ICD Indicator to identify which version of ICD codes are being reported.

For 1500 Item Number:	See NUCC 1500 Manual Page #:	Item Name:	Our Requirements Clarified:
22	33	Resubmission code	Enter the: • Appropriate Frequency code. Use a "7" if this is a resubmission and use an "8" if this is a full void or retraction. • Internal control number (ICN) from the original claim under Original Ref. No.
23	3327	Prior Authorization Number	Not required.
24A	34	Dates of Service	Required. Please submit in MMDDYY format and exclude any slashes (/) or dashes (-).
24B	36	Place of Service	Required. Please submit with the 2-digit place of service code,
24C	37	EMG (formerly Type of Service)	Not required.
24D	38	Procedures, Services, or Supplies	Required, but please do not submit supplemental information (e.g., narrative). Drugs must be reported using appropriate HCPCS code.
24E	39	Diagnosis Pointer	Required.
24F	40	$ Charges	Required. Please submit anesthesia in MMM format; e.g. one hour as 060. Please round up and do not use fractions or units.
24G	41	Days or Units	Required. Submit anesthesia in whole minutes, not units, and round up. We don't use fractions or units.
24H	42	EPSDT/Family Plans	Not required.
24I	43	ID Qualifier	Not required.
24J upper	44	Rendering Provider ID # (Legacy)	Not required.
24J lower	44	Rendering Provider NPI #	Required.
25	48	Federal Tax ID Number	Required.
26	48	Patient's Account No.	Not required.
27	49	Accept Assignment?	Required.
28	49	Total Charge	Required. Enter the sum of all line charges reported in 24F. If submitting continuous claims, total each claim individually. Please do not submit with a decimal point or dollar sign.

For 1500 Item Number:	See NUCC 1500 Manual Page #:	Item Name:	Our Requirements (that differ from the NUCC Manual):
29	50	Amount Paid	Not required.
30	50	Reserved for NUCC use	Not required.
31	51	Signature of Physician or Supplier Including Degrees or Credentials	Required.
32	52	Servicing Facility Location Information	Required. Facility's name and address are required if services were rendered outside of the home or office. Place of service values: 21 (inpatient), 22 (outpatient), 24 (ambulatory surgical); 32 or 33 (nursing home), 31 (skilled nursing facility). Do not include a phone number. **NOTE:** Please leave this field blank for services rendered in the home or office.
32a	52	Servicing Facility Location Information NPI #	Required. The facility's NPI should be reported for services rendered outside of the home or office. Leave this field blank if services were rendered in the home or office, or if the facility's NPI is not known.
32b	53	Servicing Facility Location Information Other ID #	Not required
33	54	Billing Provider Info & Phone #	Required.
33a	54	Billing Provider NPI#	Enter the NPI of the group provider you want to receive payment for the claim.
33b	55	Billing Provider Info Other ID # (formerly Group #)	Not required.

Items Not Required for Processing

*exceptions noted

For 1500 Item Number:	See NUCC 1500 Manual Page #s:	Item Name:
1	9	Medicare, Medicaid, TRICARE , CHAMPVA, Group Health Plan, FECA, Black Lung, Other
8	15	Reserved for NUCC use
10d	19	Claim codes
11	19	Insured's Policy, Group, or FECA Number
11a	20	Insured's Date of Birth
11c	21	Insurance Plan Name or Program Name
16	25	Dates Patient Unable to Work in Current Occupation
17	26	Name of Referring Provider or Other Source * Required for Independent Clinical Labs and Durable Medical Equipment (DME) providers
17a	27	Other ID #
17b	27	National Provider Identifier (NPI) * Required for Independent Clinical Labs and Durable Medical Equipment (DME) providers
19	29	Additional claim information (designated by NUCC); see item 32 for Service Facility Location Information
20	31	Outside Lab Charges
22	33	Resubmission
23	33	Prior Authorization Number
24C	37	EMG (formerly Type of Service)
24H	42	EPSDT/Family Plans (lines 1-6); future updates will be made
24I	43	24D Qualifier
26	48	Patient's Account No.
29	50	Amount Paid
30	50	Reserved for NUCC use

Best Practices for Completing Claims

We encourage you to submit 1500-formatted claims via one of our electronic technologies. Electronic claims are processed quicker and more accurately than paper claims. If you must submit paper claims, please use the standard NUCC 1500 claim form. We process paper claims through an Optical Character Recognition (OCR) scanning and imaging device. Please follow these guidelines to ensure your paper claims are processed accurately.

IMPORTANT NOTE: As of April 1, 2014 we require that all claims be billed on the red 1500 (02/12) form. Claims submitted on the old1500 (08/05) form will be returned. Claims submitted without a rendering and/or billing National Provider Identifier (NPI) will be returned.

When ordering forms

Before placing an order for forms from your vendor, confirm that the forms meet NUCC and CMS guidelines. Look for the version (02/12) of the form with the Quick Response Code box printed in black ink in the top left corner. The remainder of the form should be printed in Flint J-6983 OCR red “dropout” ink.

Align the form

Align your form carefully so that all data fall within the blocks on the claim form. You’ll be able to keep your form aligned if you center an “X” in the boxes at the top right and left corners of the form. Please be sure that all line-item information appears on the same horizontal line.

Toner cartridges

Change your printer toner cartridges often. Light print increases the chance for payment errors. Use black ink only.

Fonts

A 10-point font with a 10-pitch setting works best with the new forms. Courier or Courier New 10 monospace fonts work best with our scanner technology. Don’t mix fonts or use italics, script, percent signs, question marks, slashes, dashes, decimal points, dollar signs, or parentheses.

Do not hand write

If you submit paper claims, please explore using a software program that will print the claims on the NUCC form. Handwritten claims increase billing office costs and are more costly to process. Poor handwriting contributes to payment errors. If billing software is too costly for the volume of claims that your practice submits, please use a typewriter to complete the claim form.

Keep it clean

Don’t print, write, or stamp extra data on the claim form. Please refrain from using correction fluid or correction tape. If an error occurs while completing the claim, please complete a new red form.

Use UPPERCASE

Use only UPPERCASE letters for alphabetical entries.

Mailing/Ordering 1500 Forms

Where to send completed claims

Send your paper claims for our members and paper claims for members of other BCBS Plans to this address:

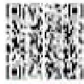
Blue Cross Blue Shield of MA
P.O. Box 986020
Boston, MA 02298

How to order blank forms

Print specifications are available in Appendix B of the *NUCC 1500 Claim Reference Instruction Manual*, and are also posted on the NUCC website at **http://nucc.org/**.

To receive copies of the 1500 form by mail, please contact your forms distributor.

Sample 1500 Claim Form with NPI



HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) [X] | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): XXA999999999

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

3. PATIENT'S BIRTH DATE (MM DD YY): 01 01 1980 — SEX: M [X] F

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

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 25 TECHNOLOGY PLACE

CITY: HINGHAM | STATE: MA

ZIP CODE: 02043 | TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789D

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO [X]

b. AUTO ACCIDENT? YES [X] NO — PLACE (State): MA

c. OTHER ACCIDENT? YES NO [X]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM DD YY): 01 01 1980 — SEX: M [X] F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 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.

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 ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY): 01 31 2014 QUAL. 431

15. OTHER DATE: QUAL. 454 — MM DD YY: 01 31 2014

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM ____ TO ____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN TOM JONES

17a.

17b. NPI 1234567899

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM ____ TO ____

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 9

A. 786.50 B. 789.00 C. 300.01 D. 300.4

E. 250.00 F. 250.01 G. 486 H. 719.46

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	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 CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02 01 14	02 01 14	12	Y	99281		ABCD	100 00	001		NPI	M98765 / 1234567890
2	06 13 13	06 13 13	12	Y	99282		EFGH	100 00	001		NPI	M98765 / 1234567890
3	06 14 13	06 14 13	12	Y	99283		A	100 00	001		NPI	M98765 / 1234567890
4	06 15 13	06 15 13	12	N	E0935		C	100 00	001		NPI	M98765 / 1234567980
5	06 16 13	06 16 13	12	N	99233		D	100 00	001		NPI	M98765 / 1234567980
6	06 17 13	06 17 13	12	Y	01999		AFH	300 00	001		NPI	M98765 / 1234567890

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 — SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: SMITHJOHN

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

28. TOTAL CHARGE: $ 800 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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 ON FILE DATE 12/13

32. SERVICE FACILITY LOCATION INFORMATION

SERVICE FACILITY NAME
1234 MAIN STREET
ANYTOWN, US 12345-1234

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (555) 555-1212

BILLING PROVIDER NAME
1234 MAIN STREET
ANYTOWN, US 12345-1234

a. 1234567890 b. M98765

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM CMS 1500 (02-12)