



Provider Claims Filing Instructions

for

AmeriHealth Caritas New Hampshire

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Claim Filing

AmeriHealth Caritas New Hampshire, hereafter referred to as the Plan (where appropriate), is required by contract and New Hampshire and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to help ensure timely processing of claims.

In accordance with 42 C.F.R. §438.602(b), health care providers interested in participating in the AmeriHealth Caritas New Hampshire network must be screened and enrolled as a Medicaid provider by the appropriate New Hampshire agency and shall be periodically reenrolled. This applies to non-participating in and/or out of the State providers as well. Claims for all services provided to Plan members must be submitted by the provider who performed the services.

Submitting Claims

Electronic/EDI

Use the payer ID for AmeriHealth Caritas New Hampshire: **87716**.

Paper/Mail

AmeriHealth Caritas New Hampshire
Attn: Claims Processing Department
P.O. Box 7387
London, KY 40742-7387

Claims filed with the Plan are subject to verification procedures including:

- All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN and Location Numbers).
- All 837 claims with Claim Attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.
- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas New Hampshire.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the Plan is the “payer of last resort” on all claims submitted to AmeriHealth Caritas New Hampshire.

When required data elements are missing or are invalid, claims will be **rejected** by the Plan for correction and re-submission. Please consider the following definitions of clean, rejected, corrected, and denied claims.

Definition: *A clean claim is a claim for payment for a health care service, which has been received by AmeriHealth Caritas NH, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with 42 CFR §447.45(b), the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.*

Definition: *Rejected claims* are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, 4

such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim.

Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 120 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

- Rejected paper claims have a letter attached with a document control number (DCN).
- A DCN is not an AmeriHealth Caritas New Hampshire claim number. A rejected claim should be resubmitted as an original claim.
- Since rejected claims are considered original claims, timely filing limits should be followed.

Definition: Denied claims are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim (see below) may be submitted to have the claim reprocessed.

Definition: Corrected claim is defined as a claim that AmeriHealth Caritas New Hampshire processed based on the information submitted but the provider submits a claim correcting the original data. A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted as indicated below as well as the correct frequency code.

Claim Filing Deadlines

Original claims must be submitted to the Plan within 120 calendar days from the date services were rendered or compensable items were provided (or the date of discharge for inpatient hospital admissions), unless there is an exception as described below.

Exceptions

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB.

Good cause exceptions will accommodate events such as a member providing the wrong Medicaid identification number, a natural disaster, or a failure of information technology systems. Good cause exceptions will be considered on a case-by-case basis. To initiate a good cause exception, please contact your provider account executive.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

Claims **originally rejected for missing or invalid data elements** must be corrected and re-submitted within 120 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system.

Corrected Claims

A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted, as indicated below, as well as the correct frequency code.

- You can find the [original](#) claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet.
- **If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to determine the claim number.**

Corrected/replacement and voided claims may be sent electronically or on paper.

- If sent electronically, the **claim frequency code** (found in the **2300 Claim Loop** in the field **CLM05-3** of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '7' for the Replacement (correction) of a prior claim and '8' for the void of a prior claim. The value '6' should not be sent.
- In addition, the submitter must also provide the original Plan claim number in **Payer Claim Control Number** (found in the **2300 Claim Loop** in the **REF*F8** segment of the HIPAA Implementation Guide for 837 Claim Files).

Claim Inquiries

An inquiry is a question from providers regarding how a claim was paid. Inquiries may be made via phone, NaviNet inquiry, or written correspondence. An inquiry may or may not result in a change in the payment.

You may initiate a claims inquiry via NaviNet with the claims adjustment inquiry function. Inquiries may also be submitted by telephone to Provider Claims Services at 1-888-599-1479. (Select the prompts for the correct Plan, and then, select the prompt for claim issues.) If submitting via paper or NaviNet, please include the original claim number.

If you prefer to write, please address the letter to:

AmeriHealth Caritas New Hampshire
Attn: Claims Processing Department
P.O. Box 7387
London, KY 40742-7387

Provider Appeals

AmeriHealth Caritas New Hampshire providers may file an appeal of a denial of claims for services rendered that have not been filed as a member appeal.

Provider appeals must be submitted in writing, along with supporting documentation. A telephone inquiry regarding payment or denial of a claim does not constitute an appeal of the claim. Provider appeals must be filed in writing and within 30 calendar days of:

- The date of the Plan's notice of the adverse action to be taken, or
- The date on which the Plan should have taken a required action but failed to do so.

Providers may submit claims appeals in writing to:

AmeriHealth Caritas New Hampshire

Attn: Provider Appeals
PO Box 7388
London, KY 40742-7388

State Fair Hearing

A provider may pursue a State fair hearing after exhausting the Plan's provider appeals process or if the Plan has not adhered to notice and timing requirements.

Please refer to the *Provider Manual* for complete instructions on submitting appeals and requests for a State fair hearing.

Refunds for Claims Overpayments or Errors

The Plan and the New Hampshire Department of Health & Human Services (DHHS) encourage providers to conduct regular self-audits to ensure accurate payment.

Medicaid program funds that were improperly paid or overpaid must be returned. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make arrangements to return the funds to the Plan for returning improper payments or overpayment within 60 calendar days from the date the overpayment is identified. Overpayments not returned within 60 calendar days from the date the overpayment was identified may be a violation of State or federal law.

Contact Provider Claim Services at 1-888-599-1479 and follow the prompts to arrange the repayment.

There are two ways to return overpayments to the Plan:

1. Have the Plan deduct the overpayment/improper payment amount from future claims payments.
2. Submit a check for the overpayment/improper amount directly to:
AmeriHealth Caritas New Hampshire
Attn: Provider Refunds
P.O. Box 7320
London, KY 40742

Note: Please include the member's name and ID, date of service, and Claim ID.



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID# DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BULK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <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"/>)		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			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) YES <input type="checkbox"/> NO <input type="checkbox"/>		b. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____		c. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10a. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> #yes, complete items 9, 9a, and 9d.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate the nature of any financial 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 _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL: _____					15. OTHER 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. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service (no below (24E)) ICD 9d. _____					22. 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 PORTER _____	F. \$ CHARGES _____	G. DAYS OR UNITS _____	H. RUSH FEE (Mark H) _____	I. ID, QUAL, _____	J. RENDERING PROVIDER ID, # _____
1											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER _____ SSN: EIN _____			26. PATIENT'S ACCOUNT NO. _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____	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.)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # ()					
SIGNED _____			SIGNED _____			SIGNED _____					
DATE _____			DATE _____			DATE _____					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Claim Form Field Requirements

The following charts describe the required fields that must be completed for the standard Centers for Medicare & Medicaid Services (CMS) CMS-1500 or UB-04 claim forms. If the field is required without exception, an “R” (Required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (Conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. **All claims must be submitted within the required filing deadline of 120 days from the date of service** unless a good cause exception (as defined herein) applies.

Required Fields (CMS-1500 Claim Form):

*Required [R] fields must be completed on all paper and electronic claims. Conditional [C] fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
N/A	Carrier Block			2010BB	NM103 N301 N302 N401 N402 N403	
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09	Titled Claim Filing Indicator code in 837P.
1a	Insured I.D. Number	Health Plan’s member identification number. If submitting a claim for a newborn that does not have an identification number, enter the mother’s ID number. Enter the member’s ID number exactly the way it appears on their Plan-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
2	Patient's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the member's Health Plan I.D. card. If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Refer to page 69 for additional newborn billing information, including Multiple Births.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	Patient's Birth Date / Sex	MMDDYY / M or F If submitting a claim for a newborn, enter "newborn" and DOB/Sex	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P.
4	Insured's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the member's Health Plan I.D. card, or Enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P.
5	Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	Patient Relationship To Insured	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P.
7	Insured's Address (Number, Street, City, State, Zip+4)	If same as the patient, enter "Same". Otherwise, enter insured's information.	C	2010BA	N301 N302 N401	Titled Subscriber Address in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
	Code) Telephone (Include Area Code)				N402 N403	
8	Reserved for NUCC use	N/A	Not Required	N/A	N/S	N/A
9	Other Insured's Name (Last, First, Middle Initial)	Refers to someone other than the patient. Completion of fields 9a through 9d is Required if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique member ID then the patient is the subscriber and identified in this loop. Titled Other Subscriber Name in 837P.
9a	Other Insured's Policy Or Group #	Required if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.
9b	Reserved for NUCC use	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9c	Reserved for NUCC use	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9d	Insurance Plan Name Or Program Name	Required if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical	C	2320	SBR04	Titled other insurance group in

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
		insurance is available, or if 9a completed.				837P.
10a, b,c	Is Patient's Condition Related To:	<p>Indicate Yes or No for each category. Is condition related to:</p> <ul style="list-style-type: none"> a) Employment b) Auto Accident c) Other Accident 	R	2300	CLM11	Titled related causes code in 873P.
10d	Claim Codes (Designated by NUCC)	<p>To comply with DHS' EPSDT reporting requirements, continue to use this field to report EPSDT referral codes as follows:</p> <p>YD – Dental (Required for Age 3 and above) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical</p> <p>For all other claims enter new Condition Codes as appropriate. Available 2-digit Condition Codes include nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include:</p> <ul style="list-style-type: none"> • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or Exacerbated by the Pregnancy Itself • W3 – Level 1 Appeal 	C	2300	NTE	<p>NTE 01 position – input "ADD" Upper case/capital format).</p> <p>NTE 02 position – first six character input "EPSDT=" (upper case/capital format where the sixth character will the = sign.</p> <p>Input applicable referral directly after</p>

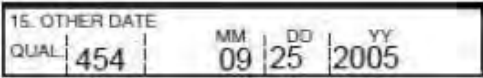
CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
						“=” For multiple code entries: Use “_” (underscore) to separate as follows: NTE*ADD*EP SDT=YD_YM_YO~
11	Insured's Policy Group Or FECA #	Required when other insurance is available. Complete if more than one other Medical insurance is available, or if “yes” to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P.
11a	Insured's Birth Date / Sex	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P.
11b	Other Claim ID	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker’s compensation or property and casualty: <ul style="list-style-type: none"> • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line; identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.
11c	Insurance Plan Name Or Program Name	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
11d	Is There Another Health Benefit Plan?	Y or N by check box. If yes, complete # 9 a-d.	R	2320		If yes, indicate Y for yes. Presence of Loop 2320 indicates Y (yes) to the question on 837P.
12	Patient's Or Authorized Person's Signature	On the 837, the following values are addressed as follows at Change Healthcare: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P.
13	Insured's Or Authorized Person's Signature		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P.
14	Date Of Current Illness Injury, Pregnancy (LMP)	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: <ul style="list-style-type: none"> • 431 – Onset of Current Symptoms or Illness • 439 – Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example: <div data-bbox="381 1732 868 1816" style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <small>14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)</small> MM DD YY QUAL 09 30 2005 QUAL 431 </div>	C	2300	DTP01 DTP03	Titled in the 837P: Date - Onset of Current Illness or Symptom Date – Last Menstrual Period
15	Other Date	MMDDYY or MMDDYYYY	C	2300	DTP01	Titled in the 837P:

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
		<p>Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include:</p> <ul style="list-style-type: none"> • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation <p>Example:</p> 			DTP03	<p>Date – Initial Treatment Date</p> <p>Date – Last Seen Date</p> <p>Date – Acute Manifestation</p> <p>Date – Accident Date – Last X-ray Date</p> <p>Date – Hearing and Vision Prescription Date</p> <p>Date – Assumed and Relinquished Care Dates</p> <p>Date – Property and Casualty Date of First Contact</p> <p>If Patient Has Had Same or Similar Illness does not exist in 837P.</p>
16	Dates Patient Unable To		C	2300	DTP01	Titled Disability

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
	Work In Current Occupation				DTP03	from Date and Work Return Date in 837P.
17	Name Of Referring Physician Or Other Source	<p>Required if a provider other than the member’s primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order:</p> <ol style="list-style-type: none"> 1. Referring Provider 2. Ordering Provider 3. Supervising Provider <p>Qualifiers include:</p> <ul style="list-style-type: none"> • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider <p>Example:</p>	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM 101 NM103 NM104 NM105 NM107	
17a	Other I.D. Number Of Referring Physician	<p>Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier.</p> <p>The NUCC defines the following qualifiers:</p> <p>OB State License Number</p>	C	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
		1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if # 17 is completed.				
17b	National Provider Identifier (NPI)	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.
18	Hospitalization Dates Related To Current Services	Required when place of service is in-patient. MMDDYY (indicate from and to date)	C	2300	DPT01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P.
19	Additional Claim Information	Claim Attachment Report Type codes in 837P defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review	Required	2300	PWK01	Claim Attachment Report Type codes in 837P

		04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet				
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CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
20	Outside Lab		C	2400	PS102	
21	Diagnosis Or Nature Of Illness Or Injury. (Relate To 24E)	<p>Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.</p> <p>Note: Claims with invalid diagnosis codes will be denied for payment. "E" codes are not acceptable as a primary diagnosis.)</p>	R	2300	HIXX-02 Where XX = 01,02,03, 04,05,06, 07,08,09, 10,11,12	
22	Resubmission Code and/or Original Ref. No	<p>This field is required for resubmissions or adjustments/corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field.</p> <ul style="list-style-type: none"> • 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim 	C Required for resubmitted or adjusted claims.	2300 2300	CLM05-3 REF02 Where REF01 = F8	<p>Titled Claim Frequency Code in the 837P.</p> <p>Titled Payer Claim Control Number in the 837P.</p> <p>Send the original claim number if this field is used.</p>
23	Prior Authorization Number	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an	C	2300	REF02 Where REF01 –	Titled Prior Authorization Number in

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Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
	CLIA Number Locations	<p>authorization.</p> <p>Laboratory Service Providers must enter CLIA number here for the location.</p> <p>EDI claims: CLIA must be represented in the 2300 loop, REF02 element.</p>			<p>G1</p> <p>REF02 Where REF01 = 9F</p> <p>REF02 Where REF01 = X4</p>	<p>837P.</p> <p>Titled Referral Number in 837P.</p> <p>Titled Clinical Laboratory Improvement Amendment Number (CLIA Number) in 837P.</p>
24A	Date(s) Of Service	<p>“From” date: MMDDYY. If the service was performed on one day leave “To” blank or re-enter “From” Date. See below for Important Note (instructions) for completing the shaded portion of field 24.</p>	R	2400	DTP01 DTP03	Titled Service Date in 837P.
24B	Place Of Service	<p>Enter the CMS standard place of service code.</p> <p>“00” for place of service is not acceptable.</p>	R	2300 2400	CLM05-1 SV105	<p>Titled Facility Code Value in 837P.</p> <p>Titled Place of Service Code in 837P.</p>
24C	EMG	<p>This is an emergency indicator field. Enter Y for “Yes” or leave blank for “No” in the bottom (unshaded area of the field).</p>	C	2400	SV109	Titled Emergency Indicator in 837P.
24D	Procedures, Services Or Supplies CPT/HCPCS	<p>Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service.</p> <p>Note: Modifiers affecting reimbursement</p>	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in

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	Modifier	<p>must be placed in the 1st modifier position</p> <p>*See additional information below for EDI requirements</p>				837P.
24E	Diagnosis Pointer	<p>Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4).</p> <p>Diagnosis codes must be valid ICD-10 codes for the date of service, and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.</p>	R	2400	SV107(1-4)	Titled Diagnostic Code Pointer in 837P.
24F	Charges	Enter charges. A value must be entered. Enter zero (\$0.00) or actual charged amount.	R	2400	SV102	Titled Line Item Charge Amount in 837P.
24G	Days Or Units	<p>Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable.</p> <p>(Field allows up to 3 digits)</p>	R	2400	SV104	Titled Service Unit Count in 837P.
24H	EPSDT Family Plan	<p>In Shaded area of field:</p> <p><u>AV</u> - Patient refused referral;</p> <p><u>S2</u> - Patient is currently under treatment for referred diagnostic or corrective health problems;</p> <p><u>NU</u> - No referral given; or</p> <p><u>ST</u> - Referral to another provider for diagnostic or corrective treatment.</p> <p>In unshaded area of field:</p>	C	2300 2400	CRC SV111 SV112	

CMS-1500 Claim Form

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Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
		<p>“Y” for Yes – if service relates to a pregnancy or family planning</p> <p>“N” for No – if service does not relate to pregnancy or family planning</p>				
24I	ID Qualifier	<p>If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I.</p> <p>G2 Provider Commercial Number</p> <p>If the rendering provider does have an NPI see field 24J below...</p> <p>If the Other ID number is the Health Plan ID number, enter G2.</p>	R	2310B	REF01 NM108	<p>Titled Reference Identification Qualifier in 837P.</p> <p>XX required for NPI in NM109.</p>
24J	Rendering Provider ID	<p>The individual rendering the service is reported in 24J.</p> <p>Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID.</p> <p>Enter the NPI number in the unshaded area of the field. Use qualifier</p>	R	2310B	REF02 NM109	<p>Change HealthCare will pass this ID on the claim when present.</p> <p>NPI</p>
25	Federal Tax I.D. Number SSN/EIN	Physician or Supplier's Federal Tax ID numbers.	R	2010AA	REF01 REF02	<p>Titled Reference Identification Qualifier and Billing Provider Tax Identification Number in the 837P.</p> <p>Where REF01 Qualifier EI =</p>

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
						Tax ID Where REF01 Qualifier SY = SSN
26	Patient's Account No.	The provider's billing account number.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	Accept Assignment	Always indicate Yes . Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.
28	Total Charge	Enter charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated services. Blank is not acceptable.	R	2300	CLM02	Titled Total Claim Charge Amount in the 837P. May be \$0.
29	Amount Paid	Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	Reserved for NUCC Use		Not Required			
31	Signature Of Physician Or Supplier Including Degrees Or Credentials / Date	Actual signature is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
32	Name and Address of Facility Where Services Were Rendered (If other than Home or Office)	Required unless #33 is the same information. Enter the physical location. (P.O. Box #'s are not acceptable here)	R	2310C	NM103 N301 N401 N402 N403	
32a.	NPI number	Required unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b.	Other ID#	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers used in 5010A1: OB State License Number G2 Provider Commercial Number LU Location Number Required when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P.
33	Billing Provider Info & Ph. #	Required – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. Boxes are not acceptable	R	2010AA	NM103 NM104 NM105 NM107 N301	

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Loop ID	Segment	Notes
					N401 N402 N403 PER04	
33a.	NPI number	Required unless Rendering Provider is an Atypical Provider and is not required to have an NPI number	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.
33b.	Other ID#	<p>Enter the Health Plan ID # (strongly recommended)</p> <p>Enter the G2 qualifier followed by the Health Plan ID #</p> <p>The NUCC defines the following qualifiers:</p> <p>G2 Provider Commercial Number</p> <p>ZZ Provider Taxonomy</p> <p>Required when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.</p>	C Recommended	2000A 2010BB	PRV03 REF02 where REF01 = G2	<p>Titled Provider Taxonomy Code in 837P.</p> <p>Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P.</p>

Required Fields (UB-04 Claim Form):

1		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL																																			
8 PATIENT NAME				9 PATIENT ADDRESS																																					
10 BIRTHDATE		11 SEX		12 DATE		13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACCT STATE		30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38 OCCURRENCE DATE		39 OCCURRENCE DATE		40 OCCURRENCE DATE		41 OCCURRENCE DATE		42 OCCURRENCE DATE		43 OCCURRENCE DATE		44 OCCURRENCE DATE		45 OCCURRENCE DATE		46 OCCURRENCE DATE		47 OCCURRENCE DATE		48 OCCURRENCE DATE		49 OCCURRENCE DATE		50 OCCURRENCE DATE			
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		51		52		53		54		55		56		57		58		59		60					
50 PRVYR NAME		51 HEALTH PLAN ID		52 REL. INFO		53 ASQ BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRVYR ID		58		59		60		61		62		63		64		65		66		67		68					
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66		67		68		69		70		71		72		73		74		75		76		77		78		79		80							
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 OTHER PROCEDURE CODE		77 OTHER PROCEDURE CODE		78 OTHER PROCEDURE CODE		79 OTHER PROCEDURE CODE		80 OTHER PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE CODE		83 OTHER PROCEDURE CODE		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 OTHER PROCEDURE CODE		87 OTHER PROCEDURE CODE		88 OTHER PROCEDURE CODE		89 OTHER PROCEDURE CODE		90 OTHER PROCEDURE CODE		91 OTHER PROCEDURE CODE		92 OTHER PROCEDURE CODE					
80 REMARKS		81 OC		82		83		84		85		86		87		88		89		90		91		92		93		94		95		96		97		98					

SAMPLE

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
1	Unlabeled Field NUBC – Billing Provider Name, Address and Telephone Number	Service Location, no PO Boxes Left justified Line a: Enter the complete provider name. Line b: Enter the complete address Line c: City, State, and Zip code + 4 Line d: Enter the area code, telephone number.	R	R	2010 AA	NM1/85 N3 N4	
2	Unlabeled Field NUBC – Pay-to Name and Address	Enter Remit Address. No PO Boxes Enter the Facility Provider I.D. number. Left justified	R	R	2010 AB	NM1/87 N3 N4	Pay to Name Pay to Address
3a	Patient Control No.	Provider's patient account/control	R	R	2300	CLM01	Patient's Control Number

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		number					
3b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference Number
4	Type Of Bill	<p>Enter the appropriate three or four - digit code.</p> <p>1st position is a leading zero – Do not include the leading zero on electronic claims.</p> <p>2nd position indicates type of facility.</p> <p>3rd position indicates type of care.</p> <p>4th position indicates billing sequence.</p>	R	R	2300	CLM05	<p>If Adjustment or Replacement or Void claim, include frequency code as the last digit.</p> <p>Include the frequency code by using bill type in loop 2300. Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. No dashes or spaces.</p>
5	Fed. Tax No.	Enter the number assigned by the federal	R	R	2010 AA	REF02 Where REF01 = EI	Pay to provider = Billing Provider use

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		government for tax reporting purposes.					2010AA Billing Provider Tax ID
6	Statement Covers Period From/Through	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDCCYY Statement Dates
7	Unlabeled Field	Not Used. Leave Blank.	N/A	N/A	N/A	N/A	N/A
8a	Patient Identifier	Patient Health Plan ID is conditional if number is different from field 60	R	R	2010 BA 2010 CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber Use 2010BA Subscriber ID Patient is not =Subscriber, Use 2010CA Patient ID
8b	Patient Name	Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the Health Plan	R	R	2010 BA 2010 CA	NM103,NM104,NM107 where NM101=IL NM103,NM104,NM107 where NM101 = QC	Patient =Subscriber Use 2010BA Subscriber Name Patient is not =Subscriber, Use 2010CA

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>ID card.</p> <p>Use a comma or space to separate the last and first names.</p> <p><u>Titles</u> (Mr., Mrs., etc.) should not be reported in this field.</p> <p><u>Prefix</u>: No space should be left after the prefix of a name e.g., McKendrick.</p> <p><u>Hyphenated names</u>: Both names should be capitalized and separated by a hyphen (no space).</p> <p><u>Suffix</u>: A space should separate a last name and suffix.</p> <p><u>Newborns and Multiple Births</u>: If submitting a claim for a newborn that does not have</p>					Patient Name

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		an identification number, enter “Baby Girl” or “Baby Boy” and last name. Refer to page 69 for additional newborn billing information, including Multiple Births.					
9a-e	Patient Address	The mailing address of the patient 9a. Street Address 9b. City 9c. State 9d. ZIP Code + 4 9e. Country Code (report if other than USA)	R	R	2010 BA 2010 CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04	Patient =Subscriber, Use 2010BA Subscriber Address Patient is not =Subscriber, Use 2010CA Patient Address
10	Patient Birth Date	The date of birth of the patient Right-justified; MMDDYYYY	R	R	2010 BA 2010 CA	DMG02 DMG02	Subscriber Demographic Info
11	Patient Sex	The sex of the patient recorded	R	R	2010	DMG03	Subscriber Demographic

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		at admission, outpatient service, or start of care. M for male, F for female or U for unknown.			BA 2010 CA	DMG03	Info
12	Admission Date	The start date for this episode of care. For inpatient services, this is the date of admission. Right-justified	R	R	2300	DTP03 where DTP01=435	Required on inpatient.
13	Admission Hour	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill types other than 21X.	R	2300	DTP03 where DTP01=435	Required on inpatient. Admission date/HR
14	Admission Type	A code indicating the priority of this admission/visit.	R	R	2300	CL101	Institutional Claim Code
15	Point of Origin for Admission or Visit	A code indicating the source of the referral for this	R	R	2300	CL102	Institutional Claim Code

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		admission or visit.					
16	Discharge Hour	Valid national NUBC Code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01=096	
17	Patient Discharge Status	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	R	R	2300	CL103	Institutional Claim Code
18 - 28	Condition Codes The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover	When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed:	C	C	2300	HIXX-2 Where XX = 01,02,03,04,05,06,07,08,09,10,11,12	HIXX-1=BG Condition info

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
	Nursing Facility Services Applicable Condition Codes: X2 – Medicare EOMB on File X4 – Medicare Denial on File	Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing: <ul style="list-style-type: none"> • There was no 3-day prior hospital stay • The resident was not transferred within 30 days of a hospital discharge • The resident’s 100 benefit days are exhausted • There was no 60-day break in daily skilled care • Medical Necessity Requirements are not met • Daily skilled care 					

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		requirements are not met All other fields must be completed as per the appropriate billing guide					
29	Accident State	The accident state field contains the two-digit state abbreviation where the accident occurred. Required when applicable.	C	C	2300	REF02 Where REF01 = LU	
30	Unlabeled Field	Leave Blank	N/A	N/A	N/A	N/A	Reserved for future use
31a,b – 34a,b	Occurrence Codes and Dates	Enter the appropriate occurrence code and date. Code must be 01 – 69, or A0-A9 or B1. Dates must be in YYYYMMDD format. Required when	C	C	2300	HIXX-2	HIXX-1 = BH

UB-04 Claim Form

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Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		applicable.					
35a,b – 36a,b	Occurrence Span Codes And Dates	A code and the related dates that identify an event that relates to the payment of the claim. Code must be 70 – 99 or M0-Z9. Dates must be in MMDDYY format. Required when applicable.	C	C	2300	HIXX-2 Where XX = 01,02,03,04,05,06,07,08,09,10,11,12	HIXX-1 = BI
37a,b	EPSDT Referral Code	Required when applicable. Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above) YO – Other YV – Vision YH – Hearing	C C C C C	C C C C C	2300	NTE	NTE 01 position – input “ADD” Upper case/capital format). NTE 02 position – first six character input “EPSDT=” (upper case/capital format where the sixth character will be the = sign). Input applicable referral directly

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		YB – Behavioral YM – medical	C C	C C			after “=” For multiple code entries: Use “_” (underscore) to separate as follows: NTE*ADD*EPSD T=YD_YM_YO~ Use NTE with HIPAA Compliant codes.
38	Responsible Party Name and Address	The name and address of the party responsible for the bill.	C	C	N/A	N/A	N/A
39a,b, c,d – 41a,b, c,d	Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Codes and	C	C	2300	HIXX-2 HIXX-5 Where XX = 01,02,03,04,05,06,07,08,09,10,11,12	HIXX-1 = BE

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>amounts. If more than one value code applies, list in alphanumeric order. Required when applicable. Note: If value code is populated then value amount must also be populated and vice versa. Please see NUCC Specifications Manual Instructions for value codes and descriptions.</p> <p>Documenting covered and non-covered days: Value Code 81 – non-covered days; 82 to report co-insurance days; 83- Lifetime reserve days. Code in the code portion and the Number of Days in the “Dollar”</p>					

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		portion of the “Amount” section. Enter “00” in the “Cents” field.					
42	Rev. Cd.	<p>Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.</p> <p>Hospital: Enter the rev code that corresponds to the rev description in field 43. Refer to NUBC for valid rev codes. The last entry on the claim detail lines should be 0001 for total charges.</p> <p>PPED: use the rev code that appears on the approved prior authorization letter for covered</p>	R	R	2400	SV201	Revenue Code

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>services.</p> <p>LTC state facility: use rev code 0100 for room and board, plus ancillary</p> <p>LTC non-state/assisted living: use rev code 0101 for room and board, without ancillary. Use appropriate rev code for covered ancillary service.</p> <p>Leave of Absence codes: LTC – state and non-state facilities: use LOA rev codes 0183, 0185 and 0189 as appropriate.</p> <p>Assisted Living Facilities: use only 0189 as a LOA code, no payment is made for days billed with rev</p>					

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		code 0189. Use for any days when patient is out of the facility for the entire day.					
43	Revenue Description	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category. Use this field to enter NDC information. Refer to supplemental information section.	R	R	N/A	N/A	Not mapped in 837I.
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	1. The Healthcare Common Procedure Coding system (HCPCS)	R	R	2400	SV202-2	SV202-1=HC/HP

UB-04 Claim Form

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Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>applicable to ancillary service and outpatient bills.</p> <p>2. The accommodation rate for inpatient bills.</p> <p>3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems.</p> <p>Enter the applicable rate, HCPCS or HIPPS code and</p>					

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. (Note: NDC numbers are required for all administered or supplied drugs.)					
45	Serv. Date	Report line item dates of service for each revenue code or HCPCS/HIPPS code. Multiple-day service codes require an RR modifier.	R	R	2400	DTP03 where DTP01=472	Date of Service
46	Serv. Units	Report units of service. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number	R	R	2400	SV205	Service Units

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Note: for drugs, service units must be consistent with the NDC code and its unit of measure. NDC unit of measure must be a valid HIPAA UOM code or claim may be rejected.					

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
47	Total Charges	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges. Report grand total of submitted charges. Enter a zero (\$0.00) or actual charged amount.	R	R	2300	SV203	Total Charges
48	Non-Covered Charges	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. Required when Medicare is Primary.	C	C	2400	SV207	Non-Covered Charges
49	Unlabeled Field	N/A	Not required	Not required	N/A	N/A	Not Mapped

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
50	Payer	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2000 B	SBR	Subscriber Information
					2010 BB	NM103 where NM101=PR	Payer Name
					2320	SBR	Other Subscriber Information
					2330 B	NM103 where NM101=PR	Other Payer Name
51	Health Plan Identification Number	The number used by the health plan to identify itself.	R	R	2010 BB	NM109 where NM101=PR	Payer ID
					2330 B	NM109 where NM101=PR	Other Plan Payer ID
52	Rel. Info	Release of Information Certification Indicator. This	R	R	2300	CLM09	Release of Information code

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider have all necessary release information on file. It is expected that all released invoices contain "Y"					
53	Asg. Ben.	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08	Benefits Assignment Certification Indicator

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
54	Prior Payments	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01=D	Prior Payment Amounts
55	Est. Amount Due	Enter the estimated amount due (the difference between “Total Charges” and any deductions such as other coverage) up to two decimal places.	C	C	2300	AMT02 where AMT01 =EAF	Payment Estimated Amount Due
56	National Provider Identifier – Billing Provider	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier.	R	R	2010 AA	NM109 where NM101 = 85	NPI

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		Required if the health care provider is a Covered Entity as defined in HIPAA Regulations.					
57 A,B,C	Other (Billing) Provider Identifier	A unique identification number assigned to the provider submitting the bill by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C. Use Modifier G2 if using health plan legacy ID	C	C	2010 AA 2010 BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U	Tax ID Only sent if need to determine the Plan ID Legacy ID
58	Insured's Name	Information refers to the payers listed in field 50. In most	R	R	2010 BA	NM103,NM104,NM105 where NM101 =	Use 2010BA is insured is subscriber

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		cases this will be the patient name. When other coverage is available, the insured is indicated here.			2330 A	IL NM103,N M104,NM 105 where NM101 = IL	Other Insured Name
59	P. Rel	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000 B	SBR02	Individual Relationship code
60	Insured's Unique Identifier	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card on line B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2010 BA	NM109 where NM101= IL REF02 where REF01 = SY	Insured's Unique ID

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
61	Group Name	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000 B	SBR04	Subscriber Group Name
62	Insurance Group No.	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000 B	SBR03	Subscriber Group or Policy Number
63	Treatment Authorization Codes	Enter the Health Plan referral or authorization number. Line A	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		refers to the primary payer; B, secondary; and C, tertiary.					
64	DCN	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. Note: Resubmitted claims must contain the original claim ID	C	C	2300	REF02 where REF01 = F8	Original Claim Number
65	Employer Name	The name of the employer that provides health care coverage for the insured individual	C	C	2320	SBR04	

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.					
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. Note: Claims with invalid codes will be denied for payment.	Not Required	Not Required	N/A	N/A	Not Required
67	Prin. Diag. Cd. and Present on Admission (POA) Indicator	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or	R	R	2300	HIXX-2 HIXX-9 Where HI01-1 = ABK	Principal Diagnosis POA

UB-04 Claim Form

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			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.					
67 A - Q	Other Diagnosis Codes	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = ABF	Other Diagnosis Information

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
68	Unlabeled Field	N/A	N/A	N/A	N/A	N/A	Not Mapped
69	Admitting Diagnosis Code	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. Required for inpatient and outpatient	R	R	2300	HI01-2 Where HI01-1= ABJ	Admitting diagnosis
70	Patient's Reason for Visit	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2 HI01-1= APR Where XX = 01,02,03	Patient Reason for visit
71	Prospective Payment System (PPS) Code	The PPS code assigned to the claim to identify the DRG based on the grouper software called	C	C	2300	HI01-2 Where HI01-1 = DR	DIAGNOSIS Related Group (DRG) Information

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.					
72a-c	External Cause of Injury (ECI) Code	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury “E” diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C	2300	HIXX-2 Where HIXX-1 = ABN	External Cause of Injury
73	Unlabeled Field	N/A	N/A	N/A	N/A	N/A	Not Mapped
74	Principal Procedure code and Date	The appropriate ICD code that identifies the principal procedure	C	C	2300	HI01-2 HI01-4 Where	

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>performed at the claim level during the period covered by this bill and the corresponding date.</p> <p>Inpatient facility – Surgical procedure code is required if the operating room was used.</p> <p>Outpatient facility or Ambulatory Surgical Center – CPT, HCPCS or ICD code is required when a surgical procedure is performed.</p>	R	R		HI01-1 = BBR	
74a-e	Other Procedure Codes and Dates	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates	C	C	2300	HIXX-2 Where HI01-1 = BBQ	Other Procedure Information

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		(identified by code) on which the procedures were performed. Inpatient facility – Surgical procedure code is required when a surgical procedure is performed. Outpatient facility or Ambulatory Surgical Center – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C	C			
75	Unlabeled Field	N/A	N/A	N/A	N/A	N/A	Not Mapped
76	Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#	Enter the NPI of the physician who has primary responsibility for the patient’s medical care or treatment in the upper line, and their name in	R	R	2310 A 2310 A	NM103,NM104,NM107, NM109 where NM101 = 71	REF01/0B/1G/LU/G2 (Do not send the Provider’s Plan ID)

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.</p> <p>Note: If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject.</p>			2310 A 2301 A	REF02 Where REF01 = G2	
77	Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#	Enter the NPI of the physician who performed surgery on the patient in the upper line, and	C	C	2310 B 2310	NM103,N M104,NM 107,NM10 9 where NM101 = 72	

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		<p>their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.</p> <p>Required when a surgical procedure code is listed.</p>	R	R	<p>B</p> <p>2310 B</p> <p>2310 B</p>	<p>REF02</p> <p>Where REF01 = G2</p>	
78 – 79	Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#	<p>Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient’s medical care or treatment in the upper line, and their name in the lower line,</p>	R	R	<p>2310 C</p> <p>2310 C</p> <p>2310 C</p> <p>2310</p>	<p>NM103,NM104,NM107,NM109 where NM101 = ZZ</p> <p>REF02</p> <p>Where REF01 = G2</p>	

UB-04 Claim Form

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional	Required or Conditional	Loop	Segment	Notes
		last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#			C		
80	Remarks Field	<p>Claim Attachment Report Type codes in 837I defines the following qualifiers</p> <p>03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME</p>	Required	Required	2300	PWK01	Claim Attachment Report Type codes in 837I

		<p>Checklist consent forms (Child Medical Eval)</p> <p>EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter</p> <p>CT - Certification of the Decision to Terminate Pregnancy</p> <p>AM - Ambulance Trip Notes/ Run Sheet</p>					
81CC, a-d	Code-Code Field	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C	2000 A	PRV01 PRV03	Billing Provider Taxonomy

Special Instructions and Examples for CMS-1500, UB-04 and EDI Claim Submissions

I. General Information

A. CMS-1500 Paper Claims – Field 24:

All unspecified Procedure or HCPCS codes require a narrative description be reported in the shaded portion of field 24. The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24 (or 2410/LIN and CTP segments when submitting via 837):

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

Qualifiers	Service
7	Anesthesia information
ZZ	Narrative description of unspecified code (all miscellaneous fields require this section be reported)
N4	National Drug Codes
VP	Vendor Product Number Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
CTR	Contract rate

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

B. EDI – Field 24D (Professional)

Details pertaining to EPSDT, Anesthesia Minutes, and corrected claims may be sent in Notes (NTE).

- Details sent in NTE that will be included in claim processing:

- Please include L1, L2, etc. to show line numbers related to the details. Please include these letters AFTER those specified below:
 - EPSDT claims need to begin with the letters EPSDT followed by the specific code as per DHS instructions
 - Anesthesia Minutes need to begin with the letters ANES followed by the specific times
 - Corrected claims need to begin with the letters RPC followed by the details of the original claim (as per contract instructions)
 - DME Claims requiring specific instructions should begin with DME followed by specific details

C. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02+ Plan’s Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. **Note:** Do not send the provider ID on the 2400 loop. This loop is not used in determining the provider ID on the claims.

D. EDI – Field 45 and 51 (Institutional)

Field 45 – Service Date must not be earlier than the claim statement date.

Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – Health Plan ID – the number used by the health plan to identify itself.

Note: AmeriHealth Caritas New Hampshire EDI Payer ID#: **87716**.

E. EDI – Reporting DME

DME Claims requiring specific instructions should begin with DME followed by specific details. Example: NTE*ADD*DME AEROSOL MASK, USED W/DME NEBULIZER

F. Reporting NDC on CMS-1500 and UB-04 and EDI

1. NDC on CMS-1500

- NDC must be entered in the shaded sections of item 24A through 24G.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information.
 - Do not enter a space between the qualifier and the 11 digit NDC number.
 - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens).
 - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Enter the NDC quantity unit qualifier
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit

- Enter the NDC quantity
 - Do not use a space between the NDC quantity unit qualifier and the NDC quantity
 - Note: The NDC quantity is frequently different than the HCPC code quantity

Example of entering the identifier N4 and the NDC number on the CMS 1500 claim form:

A. DATE(S) OF SERVICE		B. PLACE OF SERVICE				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM FAMILY PLAN	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To	YY	MM	DD	YY	EMG	CPT/HCPCS	MODIFIER							
10	01	05	10	01	05	11	J0400			1	250 00	40	N	G2	12345678901
															0123456789

N4	12345678901	U	N1
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2. NDC on UB-04

- NDC must be entered in Form Locator 43 in the Revenue Description Field.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- Report the N4 qualifier in the first two (2) positions, left-justified.
 - Do not enter spaces
 - Enter the 11 character NDC number in the 5-4-2 format (no hyphens).
 - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC

Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.

- F2 – International Unit
- GR – Gram
- ML – Milliliter
- UN – Unit
- ME – Milligram
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
 - Any unused spaces for the quantity are left blank.

Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The description field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	4	5	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

3. NDC via EDI

The NDC is used to report prescribed drugs and biologics as required by government regulation.

EDI claims with NDC info must be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDC's sent at claim line level should be submitted using CMS-1500 or UB-04 paper claim.

When submitting NDC in the LIN segment, the CTP segment is required. This segment is to be submitted with the Unit of Measure and the Quantity.

When submitting this segment, CTP03, Pricing; CTP04, Quantity; and CTP05, Unit of Measure are required.

II. Provider Preventable Conditions Payment Policy and Instructions for Submission of POA Indicators for Primary and Secondary Diagnoses

The Plan's payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. For general information about, and definitions of, PPCs, please refer to the "Quality Assessment and Performance Improvement Program" section of the *Provider Manual*.

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. Therefore, a PPC must be reported by the provider at the time a claim is submitted. Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a "Present on Admission" indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; the Plan will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and “E” diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

Inpatient Claims

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital- acquired.

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member’s medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the “Present on Admission” (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG- based facilities may submit POA via 837I in loop 2300; segment NTE, data element NTE02.

Valid POA Indicators include:

- “Y” = Yes = present at the time of inpatient admission.
- “N” = No = not present at the time of inpatient admission.
- “U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission.
- “W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not “null” = Exempt from POA reporting.

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization Invalid or Missing - A valid authorization number must be included on the claim form for all services requiring prior authorization.

Attending Physician ID Missing or Invalid – Inpatient claims must include the name of the physician who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (Attending Physician ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as 2 alpha, 6 numeric, and 1 alpha character (AANNNNNA) **OR** 2 alpha and 6 numeric characters (AANNNNNN).

Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.

Diagnosis Code Missing Required Digits – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM or ICD-10 manual for the appropriate categories, subcategories, and extensions. After October 1, 2015, three-digit category codes are required at a minimum. Refer to the coding manuals to determine when additional alpha or numeric digits are required. Use “X” as a place holder where fewer than seven digits are required. Submit the correct ICD qualifier to match the ICD code being submitted.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG codes must include this information on the claim form.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages. Payment from the previous payer may be submitted on the 837I or 837P. Besides the information supplied in this document, the line item details may be sent in the SVD segment. Include the adjudication date at the other payer in the DTP, qualifier 573. COB pertains to the other payer found in 2330B. For COB, the plan is considered the payer of last resort.

EPSDT Information Missing or Incomplete – The Plan requires EPSDT screening claims to be submitted by mail using the CMS 1500 Federal claim form, the Universal Billing form (UB-04), or electronically using the HIPAA compliant 837 Professional Claims (837P) transaction or the Institutional Claims (837I) transaction.

External Cause of Injury Codes – External Cause of Injury “E” diagnosis codes should not be billed as primary and/or admitting diagnosis. Include applicable POA Indicators with ECI codes.

Future Claim Dates – Claims submitted for Medical Supplies or Services with future claim dates will be denied, for example, a claim submitted on October 1 for bandages that are delivered for October 1 through October 31 will deny for all days except October 1.

Handwritten Claims – Handwritten claims are not accepted. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity.

Highlighted Claim Fields (See Illegible Claim Information)

Illegible Claim Information – Information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed in black ink, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate.

Incomplete Forms – All required information must be included on the claim forms in order to help ensure prompt and accurate processing.

Member Name Missing – The name of the member must be present on the claim form and must match the information on file with the Plan.

Member Plan Identification Number Missing or Invalid – The Plan’s assigned identification number must be included on the claim form or electronic claim submitted for payment.

Member Date of Birth does not match Member ID Submitted – a newborn claim submitted with the mother’s ID number will be pended for manual processing causing delay in prompt payment.

Newborn Claim Information Missing or Invalid – Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert “Baby Girl” or “Baby Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.

Payer or Other Insurer Information Missing or Incomplete – Include the name, address and policy number for all insurers covering the Plan member.

Place of Service Code Missing or Invalid – A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.

Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Spanning Dates of Service Do Not Match the Listed Days/Units – Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

Signature Missing – The signature of the practitioner or provider of service must be present on the claim form and must match the service provider name, NPI and TIN on file with the Plan.

Tax Identification Number (TIN) Missing or Invalid - The Tax I. D. number must be present and must match the service provider name and payment entity (vendor) on file with the Plan.

Taxonomy –The provider’s taxonomy number is required wherever requested in claim submissions. Enter the Taxonomy code in fields 19 and 33b of the CMS-1500. Enter the Taxonomy code in field 81 of the UB-04 when an NPI is populated in field 56.

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer’s explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims. Adjusted claims may be sent via paper or EDI.



IMPORTANT BILLING REMINDERS:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- EPSDT services may be submitted electronically or on paper.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- The *individual provider name* and NPI number as opposed to the group NPI number must be indicated on the claim form.
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- The claim for baby *must* include the *baby’s date of birth* as opposed to the mother’s date of birth. Claim must also include *baby’s birth weight (value code 54)*.
- On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith A, Baby Girl Smith B, etc.
- Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- The *individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.

- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI number's results in inaccurate payments or denials.
- When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 120 calendar days from the date of service.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 120 calendar days from the date of service.
- Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.

Electronic Data Interchange (EDI) for Medical and Hospital Claims

Electronic Data Interchange (EDI), performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of certain administrative costs. EDI eliminates the need for paper claim submission and may reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time – for example, an EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to more easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, the system has confirmed that the information needed for processing is present.
- Quicker claim completion. Claims that do not need additional investigation generally experience quicker processing timeframes.

All the same requirements for paper claim filing apply to electronic claim filing.

Important: Please allow for normal processing time (which may be approximately 30 days) before re-submitting a claim either through the EDI or paper process. This reduces the possibility of your claim being rejected as a duplicate claim.

In order to verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare Acceptance report, and the R059 Plan Claim Status Report.

Electronic Claims Submission

Electronic Claims

AmeriHealth Caritas New Hampshire contracts with Change Healthcare (CHC). As long as you have the capability to send EDI claims to CHC, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically. Electronic claim submissions to AmeriHealth Caritas New Hampshire should follow the same process as other electronic commercial submissions.

To initiate electronic claims:

- Contact your practice management software vendor or EDI software vendor.
- Inform your vendor of AmeriHealth Caritas New Hampshire's EDI Payer ID#: 87716.
- You may also contact CHC at 877-363-3666 for information on contracting for direct submission to CHC.

AmeriHealth Caritas New Hampshire does not require CHC payer enrollment to submit EDI claims. Any additional questions may be directed to the AmeriHealth Caritas New Hampshire EDI Technical Support by calling **1-833-686-2264** or by emailing to EDI.ACNH@amerihealthcaritasnewhampshire.com.

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Hardware/Software Requirements

There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Contracting with Change Healthcare and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Change Healthcare EDI capabilities, you can contact the Change Healthcare Provider Support Line at **1-800-845-6592**. You may also choose to contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

Contacting the EDI Technical Support Group

Providers interested in sending claims electronically may contact the EDI Technical Support Group for information and assistance in beginning electronic submissions.

When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or Change Healthcare to inform them you wish to initiate electronic submissions to the Plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

Important: Change Healthcare facilitates EDI Healthcare transactions around the world. It has the capability to accept electronic data from numerous providers in several standardized EDI formats and then forwards accepted information to carriers in an agreed upon format.

Contact EDI Technical Support by calling 1-833-686-2264 or by emailing to EDI.ACNH@amerihealthcaritasnewhampshire.com.

Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Payer ID for AmeriHealth Caritas New Hampshire is 87716.

NOTE: Plan payer specific edits are described in Exhibit 99 at Change Healthcare.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Change Healthcare or any other EDI clearinghouse or vendor may require additional data record requirements.

Electronic Claim Flow Description

In order to send claims electronically to the Plan, all EDI claims must first be forwarded to Change Healthcare. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits as described in Exhibit 99 at Change Healthcare. Claims not meeting the requirements are immediately rejected and sent back to the sender via a Change Healthcare error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or Change Healthcare.

Accepted claims are passed to the Plan, and Change Healthcare returns an acceptance report to the sender immediately.

Claims forwarded to the Plan by Change Healthcare are immediately validated against provider and member eligibility records. Claims that do not pass this validation step are rejected and sent back to Change Healthcare, which also forwards this rejection to its trading partner – the intermediate EDI vendor or provider. Claims passing eligibility requirements are then passed to the claim processing queues. **Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.**

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from Change Healthcare or other contracted EDI software vendors, must be reviewed and validated against transmittal records daily.

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to the Plan.

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Change Healthcare Provider Support Line at **1-800-845-6592**.

If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact EDI Technical Support by calling **1-833-686-2264** or by emailing to EDI.ACNH@amerihealthcaritasnewhampshire.com.

Important: Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Change Healthcare will produce an Acceptance report * and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments.

* An Acceptance report verifies acceptance of each claim at Change Healthcare.

** A R059 Plan Claim Status Report is a list of claims that passed Change Healthcare's validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data. Your claims must be received by the EDI vendor by 9 p.m. in order to be transmitted to the Plan the next business day.

Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or Change Healthcare to verify you receive the reports necessary to obtain this information. For support, contact Change Healthcare Provider Support Line at **1-800-845-6592**.

Invalid Electronic Claim Record Rejections

All claim records sent to the Plan must first pass Change Healthcare HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 120 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically.

837P – 005010X222A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

837I – 005010X223A2 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Important: Provider NPI number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider NPI only if the provider number fields are empty.

Important: The Plan's Provider ID is recommended as follows:

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

NPI Processing – The Plan's Provider Number is determined from the NPI number using the following criteria:

1. Plan ID, Tax ID and NPI number

2. If no single match is found, the Service Location's full 9 character ZIP code + 4 is used
3. If no service location is include, the billing address full 9 character ZIP code + 4 will be used
4. If no single match is found, the required Taxonomy is used
5. If no single match is found, the claim is sent to the Invalid Provider queue (IPQ) for processing
6. If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim The legacy Plan ID is used as the primary ID on the claim
7. If you have submitted a claim, and you have not received a rejection report, but are unable to locate your claim via NaviNet, it is possible that your claim is in review by the Plan. Please check with provider services and update you NPI data as needed. It is essential that the service location of the claim match the NPI information sent on the claim in order to have your claim processed effectively.

EDI Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient and outpatient claim types.

Excluded Claim Categories. At this time, these claim records must be submitted on paper.
--

Claim records for medical, administrative or claim appeals.

Excluded Provider Categories. Claims issued on behalf of the following providers must be submitted on paper.
--

Providers not transmitting through Change Healthcare or providers sending to Vendors that are not transmitting (through Change Healthcare) NCPDP Claims.
--

Common EDI Rejections

Invalid Electronic Claim Records – Common Rejections from Change Healthcare

Claims with missing or invalid batch level records
--

Claim records with missing or invalid required fields

Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
--

Claims without provider numbers

Claims without member numbers

Claims in which the date of birth submitted does not match the member ID.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim
--

System)
Claims received with invalid provider numbers
Claims received with invalid member numbers
Claims received with invalid member date of birth

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically...	Contact Change Healthcare Provider Support Line at: 1-800-845-6592
If you have general EDI questions ...	Contact EDI Technical Support at: 1-833-686-2264. Or via email: EDI.ACNH@amerihealthcaritasnewhampshire.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports...	Contact your EDI Software Vendor or call the Change Healthcare Provider Support Line at 1-800-845-6592
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)...	Contact Provider Claim Services at 1-888-599-1479 by following the prompts.
If you have questions about claims that are reported on the Remittance Advice....	Contact Provider Claim Services at 1-888-599-1479 by following the prompts.
If you need to know your provider NPI number...	Contact Provider Claim Services at 1-888-599-1479 by following the prompts.
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information... For questions about changing or verifying provider information...	Contact Provider Services at: 1-888-599-1479.
If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor.
Check the status of your claim:	Review the status of your submitted claims on NaviNet or open a claims investigation for submitted claims on NaviNet at www.navinet.net via the claims adjustment inquiry function.
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057

Best Practices for Submitting Corrected Claims

The corrected claims process begins when you receive an explanation of payment (EOP) from AmeriHealth Caritas New Hampshire detailing the claims processing results.

A corrected claim should only be submitted for a claim that has already paid and you need to correct information on the original submission.

Electronic data interchange (EDI) is the preferred method for submitting corrected claims due to its speed, versatility and accuracy. For convenience, the instructions for submitting paper claims are also included at the end of this section.

File a New Claim When....		File a Corrected Claim When...	
1	The claim was never previously billed	1	You received a full or partial payment on a claim but you identified that information must be corrected (some examples: billed wrong # of units, missing claim line, updates to charge amounts, adding a modifier)
2	No payment was received - If the entire claim allows zero dollars, make the appropriate changes and resubmit as a new claim. Do not submit as a corrected claim.	2	You submitted a claim for the wrong member. Submit a frequency code 8 and request a void of the original submission
3	Receive a rejection letter to a paper claim indicating invalid or required missing data elements, such as the provider tax identification number or member ID number.		
4	Received a rejection notice at your electronic claim clearinghouse (277CA) indicating invalid or missing a required data element.		
5	The original claim denied for primary carrier EOB and now you have the primary carrier EOB		
6	The claim denied for eligibility and now the eligibility has been updated and the member has active coverage.		

Adhering to the following claims filing best practices may reduce duplicate service denials and other unexpected processing results.

1. Submit all services on the corrected claim that were on the original claim plus the corrected information. This includes services that may have already paid on the original claim

submission. The corrected claim will replace all of the information on the original claim. As an example, the original claim had two lines; the correction was to add a third line. Submit all three lines not just the third line you are attempting to add.

2. Do not submit corrected services from multiple claims on one corrected claim.
3. Do not submit a corrected claim if additional information is requested, such as medical records, UNLESS a change is made to the original claim submission.
4. When changing a member ID number for a processed claim: Submit a voided claim (frequency 8) canceling charges for the original claim, AND submit a new claim with the correct member ID number.
5. Always provide the appropriate original claim number associated with the corrected claim.
6. Apply the appropriate frequency code in the defined location of the 1500/UB claim form,
7. Handwriting or stamping the words "corrected, resubmitted or voided" on the paper claim will cause the claim to be rejected.

Corrected claim instruction table:

1a: Submit Corrected Claim After receiving an 835 showing claim was Paid or Denied				
	EDI 1500	Paper 1500	EDI UB	Paper UB
Use frequency 7 for replacing a claim	2300, CLM05-3=7	Field 22, 1st character=7	2300, CLM05-3=7	Field 8, 4 th character=7
Use Frequency 8 to void or cancel a prior claim	2300, CLM05-3=8	Field 22, 1 st character=8	2300, CLM05-3=8	Field 8, 4 th character=8
Always Submit the Original Claim Number	2300, REF01= F8 and REF02= the original claim number from the 835	Field 22, characters 2-13	2320, REF01=F8 and REF02= original claim number from the 835	Field 64, characters 1-12.
1b: Submit (Re-Submit) A Claim After receiving an 835 showing claim was Rejected				
	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.

Providers using electronic data interchange (EDI) can submit “Professional” corrected claims* electronically rather than via paper to the Plan.

*Corrected claims are resubmissions of an existing claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. The successful submission of a corrected claim will cause the retraction and complete replacement of the original claim.

Your EDI clearinghouse or vendor needs to:

- ✓ Use “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use “8” to void a prior claim
- ✓ Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the Plan’s claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.

- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time

Providers using electronic data interchange (EDI) can submit “Institutional” corrected claims electronically rather than via paper to the Plan.

Your EDI clearinghouse or vendor needs to:

- ✓ Use “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use “8” to void a prior claim
- ✓ Include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the Plan’s claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time

For more information, please contact the EDI support by calling 1-833-686-2264 or emailing to: EDI.ACNH@amerihealthcaritasnewhampshire.com.

Providers using our NaviNet portal (www.navinet.net) can view their corrected claims online. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

Providers can also submit “Professional” corrected claims on the 1500 paper form.

Requirements for corrected claims using the 1500 paper form:

- ✓ Use “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use “8” to void a prior claim
- ✓ Place the number in the “Submission Code” section of the field.
- ✓ Include the original claim number in “Original Ref. No.” section of the field with no dashes or spaces.
- ✓ **Do** include the Plan’s claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time

Providers can submit “Institutional” corrected claims on the UB-04 paper form.

Requirements for corrected claims using the UB-04 paper form:

- ✓ Use “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P).
Use “8” to void a prior claim
- ✓ Include the original claim number in field 64, “DCN” (Document Control Number).
- ✓ **Do** include the Plan’s claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time

Send all corrected or resubmitted paper claims to:

AmeriHealth Caritas New Hampshire
 Attn: Claims Processing Department
 P.O. Box 7387
 London, KY 40742-7387

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 120 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on at the beginning of this document and to detailed instructions in the Best Practices for Submitting Corrected Claims section.)

Suggestion: Before resubmitting claims, check the status of both your original and corrected claims online at www.navinet.net. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

NPI Reminder: Provider NPI number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider NPI only if the provider number fields are empty.

The Plan’s Provider ID is recommended as follows:

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

Supplemental Information:

Guidance on Submitting Interim Claims

Reminder: Claim dates of service must always fall within the statement period.

	EDI 837P	Paper 1500	EDI 837I	Paper UB
Professional claims and inpatient stays that fall within the statement period:				
New admit through discharge claim; use Frequency Code 1 Admit – Discharge and make sure to include all dates of service	2400, DTP03 = DOS, 2400 SV104 = Days or Units, Otherwise N/A.	Field 24A, dates of Service: Enter From and To dates (“To’ S/B blank for single day services. Field 24G, Days or Units, Otherwise N/A.	2300, CLM05=1, also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103	Field 4, Type of Bill, last character=1 also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103
Interim billing: frequency codes for use when the inpatient stay spans statement periods or the claim exceeds claim line limits.				
New INTERIM - FIRST CLAIM for continuing services, Use frequency code (sequence code) 2 INTERIM - FIRST CLAIM	N/A	N/A	2300, CLM05, Type of Bill (TOB), last position = ‘2’, example 112 for “Inpatient – 1st Claim”,	Field 4, Type of Bill (TOB) last position = ‘2’ example 112 for “Inpatient – 1st Claim”, Field 22 Patient Status of 30 “Still Patient”

<p>Submit second claim for continuing services, Use Frequency Code (sequence code) 3 , INTERIM - CONTINUING CLAIM</p>	N/A	N/A	2300, CLM05, Type of Bill last position = '3', example: 113 for "Inpatient - Cont. Claim"	Field 4, Type of Bill last position = '3', example: 113 for "Inpatient - Cont. Claim" Field 22 Patient Status of 30 "Still Patient"
EDI 837P Paper 1500 EDI 837I Paper UB				
Interim billing: frequency codes for use when the inpatient stay spans statement periods or the claim exceeds claim line limits.				
<p>Submit final claim for continuing services, Use Frequency Code (sequence code) 4, INTERIM - INTERIM - LAST CLAIM</p>	N/A professional	N/A	2300, CLM05, Type of Bill last position = '4', example: 114 for "Inpatient - Last Claim", also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103	Field 4, Type of Bill last position = '4', example: 114 for "Inpatient - Last Claim", also required are Field 16: Discharge Hour, Field 17: Patient Discharge Status and Field 22 Patient Status, use the appropriate code for Discharged or Expired.

Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Review

We must obtain health status documentation from the diagnoses contained in claims data.

Why are retrospective chart reviews necessary?

Although the Plan captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

What is the significance of the ICD-10-CM Diagnosis code?

International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) codes are identified as 3 to 7 alpha-numeric codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-10-CM Official Guidelines for Coding and Reporting (October, 1, 2015), providers must code all documented conditions that were present at time of the encounter/visit, and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the member?

The following are examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

Amputation status	Diabetes mellitus	Multiple sclerosis
Bipolar disorder	Dialysis status	Paraplegia
Cerebral vascular disease	Drug/alcohol psychosis	Quadriplegia
COPD	Drug/alcohol dependence	Renal failure
Chronic renal failure	HIV/AIDS	Schizophrenia
Congestive heart failure	Hypertension	Simple chronic bronchitis
CAD	Lung, other severe cancers	Tumors and other cancers
Depression	Metastatic cancer, acute leukemia	(Prostate, breast, etc.)

What are your responsibilities?

Physicians must accurately report the ICD-10-CM diagnosis codes to the highest level of specificity.

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:
 - E11.40 Diabetes with neurological manifestations and E08.40 for diabetic polyneuropathy

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation is clear; concise, consistent, complete, and legible.

Please refer to the *Provider Manual* for a complete list of medical record requirements.

Physician Documentation Tips

- First list the ICD-10CM code for the diagnosis, condition, problem or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- Ensure physician signature and credentials are on each date of service documented.
- Update physician super bills annually to reflect updated ICD-10CM coding changes, and the addition of new ICD-10CM codes.

Physician Communication Tips

- When used, the SOAP note format can assist both the physician and record reviewer/coder in identifying key documentation elements.

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

Objective: Data obtained from examinations, lab results, vital signs, etc.

Assessment: Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.

Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

Evaluation and Management Codes

Supplemental Billing Information for Modifiers 25 & 59

The Current Procedural Terminology (CPT) defines modifier 25 as a “significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.” The CPT defines modifier 59 as a “distinct procedural service.”

General Guidelines for Modifier 25:

- Modifier 25 may be appended only to Evaluation and Management (E&M) codes within the range of 92002 – 92014 and 99201 – 99499.
- To appropriately append modifier 25 to an E&M code, the provided service must meet the definition of “significant, separately identifiable E&M service” as defined by CPT.
- When appending modifier 25 to an E&M service billed on the same date of service as a procedure or other service, documentation for the additional E&M must be entered in a separate section of the medical record in order to validate the separate and distinct nature of the E&M service. The additional E&M service must be able to stand alone as a billable service with no overlapping of key E&M components (e.g., medical history, medical examination, and medical decision-making performed).

General Guidelines for Modifier 59:

- Modifier 59 is used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances.
 - Modifier 59 should not be appended to an E&M code. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see modifier 25.
- When appending modifier 59, documentation must support that the procedure/service represents a different session or patient encounter, procedure or surgery, anatomic site or organ system, lesion (through a separate performed incision/excision or for a separate injury or area of extensive injuries), or procedure not typically performed on the same day by the same individual.
- Modifier 59 should only be reported if no more descriptive modifier (e.g., Modifier XE, XP, XS, or XU) is available, and it is the most accurate modifier that is available to describe the circumstances of the procedure or service.

Providers and other interested parties should refer to the National Correct Coding Initiative (NCCI) *Policy Manual for Medicaid Services* (NCCI Policy Manual) and the *Modifier 59* article (Modifier 59 Article) for detailed information regarding appropriate modifier usage, which can be found on the CMS Medicaid.gov website.

Most Common Claims Errors* for CMS-1500

The following information includes the most common claims errors observed by the AmeriHealth Caritas Family of Companies, 2018.

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"Member name is missing or illegible." (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"Member date of birth (DOB) is missing." (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"Member's sex is required." (If no box is checked, the claim will be rejected.)
4	Insured's Name	"Insured's name missing or illegible." (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address(number, street, city, state, zip+4) phone	"Patient address is missing." (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"Patient relationship to insured is required." (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address(number, street, city, state, zip+4) phone	"Insured's address is missing." (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	"Diagnosis code is missing or illegible." (The claim will be rejected.)
24	Supplemental Information	"National Drug Code (NDC) data is missing/incomplete/invalid." (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	"Date of service (DOS) is missing or illegible." (The claim will be rejected if both the "From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	"Place of service is missing or illegible." (Claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
24D	Procedure, Services or Supplies	"Procedure code is missing or illegible." (Claim will be rejected.)
24E	Diagnosis Pointer	"Diagnosis (DX) pointer is required on line ___" [lines 1-6]. (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"Line item charge amount is missing on line ___" [lines 1-6]. (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"Days/units are required on line ___" [lines 1-6]. (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible." (If NPI is missing or illegible, claim will be rejected.)
26	Patient Account/Control Number	"Patient Account/Control number is missing or illegible" (If missing or illegible, claim will reject)
27	Assignment Number	"Assignment acceptance must be indicated on the claim." (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"Total charge amount is required." (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	"Provider name is missing or illegible." (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	"Billing provider name and/or address is missing or incomplete." (If the name and/or street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	"Field 33 of the CMS1500 claim form requires the provider's physical service address including the full 9 character ZIP code + 4." (If a PO Box is present, the claim will be rejected.)

Most Common Claims Errors* for UB-04

*The following information includes the most common claims errors observed by the AmeriHealth Caritas Family of Companies, 2018.

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
1	Billing Provider Name, Address and Telephone Number	"Billing provider name and/or address missing or incomplete." (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
1	Billing Provider Name, Address and Telephone Number	"Field 1 of the UB04 claim form requires the provider's physical service address." (If a PO Box is present, the claim will be rejected.)
3a	Patient Account/ Control Number	"Patient account/control number is missing or illegible." (If the number is missing or illegible, the claim will be rejected.)
4	Type of Bill	If claim is a resubmission, include frequency code as the last digit. Include original claim number in Field 64. (If frequency code is missing or invalid, the claim will be rejected.)
8b	Patient Name	"Member name is missing or illegible." (If first and/or last name are missing or illegible, the claim will be rejected.)
9a-e	Patient Address	"Patient address is missing." (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
10	Patient Birth Date	"Member DOB is missing." (If missing month and/or day and/or year, the claim will be rejected.)
11	Patient Sex	"Member's sex is required" (If missing, the claim will be rejected.)
12	Admission Date	"Admission Date is missing or illegible." (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, do not reject claim. If it is IP and a valid date is not billed, the claim will be rejected.)
12	Admission Date	"Based on the date the claim was received, the admission date is a future date." (Use bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject claim. If it is IP and a future date is billed, reject the claim.)
13	Admission Hour	"Admission hour is required." (Use bill type table to identify if it is an IP or OP claim. If it is OP, do not reject the claim. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
		claim will be rejected.)
14	Admission Type	"Admission type is required." (If a numeric value is not present, claim will be rejected.)
15	Point of Origin for Admission or Visit	"Point of Origin for admission or visit is missing." (If claim has any bill type except 14x and the field is blank, claim will be rejected.)
16	Discharge Hour	"Discharge hour is required." (Use type if bill table to determine if it is an IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, claim will be rejected.)
17	Patient Discharge Status	"Patient discharge status is required." (If left blank, claim will be rejected.)
42	Revenue Code	"Revenue code is missing or illegible." (If the revenue code is missing or illegible, the claim will be rejected.)
45	Service Date	"DOS is missing or illegible." (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)
45	Creation Date	"Creation date is missing or illegible." (If the creation date is missing or illegible, the claim will be rejected.)
46	Service Days/Units	"Days/units are required on line __." [lines 1-22]. (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
47	Line Item Charges	"Line item charge amount is missing on line__." [lines 1-22]. (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	Total Charges	"Total charge amount is missing." (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	Payer	"Payer name is required." (If left blank, the claim will be rejected.)
52	Release of Information	"Valid release of information certification indicator is required." (If blank or invalid, the claim will be rejected.)
53	Assignment of Benefits	"Valid assignment of benefits certification indicator is required." (If blank or invalid, the claim will be rejected.)
58	Insured's Name	"Member name is missing or illegible." (If first and/or last name are missing or illegible, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
59	Patient's Relationship	"Valid patient's relationship to insured is required. " (If blank or invalid, the claim will be rejected.)
64	Document Control Number (DCN)	If claim is a resubmission, include the original claim number. Note: include frequency code in Field 4. (If original claim number is missing or invalid, the claim will be rejected.)
67A-Q	Other Diagnosis Codes and Present on Admission Indicator	" Diagnosis codes are missing or illegible. " (If diagnosis codes are missing or illegible, the claim will be rejected.)
69	Admitting Diagnosis Code	" Admitting diagnosis code is missing or illegible. " (If it is an IP claim and field is blank or illegible, the claim will be rejected.)
70	Patient's Reason for Visit	" Patient's reason for visit is missing. " (If the claim is OP and field is blank, the claim will be rejected.)
74	Other/Procedure Date	" Based on the date the claim was received, procedure date is a future date. " (Use the bill type table to identify if it is an IP or an OP claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)
74	Other/Procedure Date	" Procedure date is missing or illegible. " (Use bill type table to identify if it is an IP or and OP claim. If OP, do not reject the claim. If IP and a valid date is not billed, reject the claim.)
76	Attending Provider Identifiers: Name and NPI	" Attending physician name and/or number is missing. " (If attending physician name or NPI number are missing, the claim will be rejected.)
76	Attending Provider Qualifier	" Attending provider qualifier is missing/ invalid. " (The claim will be rejected if the "Other provider ID" is present and either: 1.) The 'Qualifier' box is blank or 2.) A qualifier other than 0B/1G/G2 is present.
76	Attending Provider Other ID#	" Attending Provider NPI is missing. " (The claim will be rejected if qualifier is present and Other ID box is blank.)