

CMS-1500 Workshop

Presented by
Mina Reynaga
Provider Field Representative



ACS Government Healthcare
Affiliated Computer Services, Inc.
A Xerox Company



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ACS Helpdesks

Call 505-246-0710 or 800-299-7304 - to directly reach all provider help desks including Provider Relations, Provider Enrollment, the HIPAA/EMC help desk and TPL.



ACS Info

For all contact, Claims, and Correspondence Addresses information go to the following link on the New Mexico Medicaid Web Portal:

- <https://nmmedicaid.acs-inc.com/nm/general/loadstatic.do?page=ContactUs.htm>



Important State Websites

STATE WEBSITE:

PROGRAM POLICY MANUAL

- <http://www.hsd.state.nm.us/mad/policymanual.html>

BILLING INSTRUCTIONS

- <http://www.hsd.state.nm.us/mad/billinginstructions.html>

REGISTERS AND SUPPLEMENTS:

- <http://www.hsd.state.nm.us/mad/registers/>



ACS Field Representatives



Provider Field Representative:

Mina Reynaga- (505) 246-9988 Ext. 223;
(800) 282-4477 Ext 223

- E-mail: Erminia.Reynaga@acs-inc.com

IMPORTANT UPDATE!

Electronic Funds Transfers (EFT)

As of May 1, Medical Assistance Division policy requires payment to be made only via electronic funds transfer (EFT). As stated in section 8.302.2.9, "MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made." (Please see Program Policy Manual)

IMPORTANT UPDATE!

Electronic Funds Transfers (EFT)

**ELECTRONIC FUNDS TRANSFER
HUNDREDS OF PROVIDERS HAVE SIGNED UP!**

PLEASE GO TO  TODAY!

**How to sign up for Electronic Fund Transfer
Easy four step process**

Step One:

Log in to the New Mexico Medicaid Portal as the Master Administrator. In the Links on the left hand side, click on Email/EFT Administration.

Step Two:

Enter your EIN or SSN in the marked box.



The screenshot shows the user interface of the New Mexico Medicaid Portal. On the left is a navigation menu with the following items: Eligibility, Claim Status, Prior Authorization, Payment History, Administration, User Home, Change Password, Web Registration, Change Provider, User Administration, Email/EFT Administration (highlighted with a red box), NPI Submission, Reports & Files, Reports & Data Files, Eligibility, Claim Status, Prior Authorization, Payment History, Administration, User Home, Change Password, Web Registration, Change Provider, and User Administration. The main content area is titled 'User Home' and displays a welcome message for 'Welcome Idiaz99 (Luis Diaz)!' and the current date and time. Below this is a section titled 'Email/EFT Administration - Verify EIN/SSN' which contains a text box for entering the EIN/SSN, a 'Submit' button, a 'Clear' button, and a 'Cancel' button. The text box is highlighted with a red box.

IMPORTANT UPDATE!

Electronic Funds Transfers (EFT)

Step Three:

You will need to fill in your account type, account number and bank routing transit number. You will also need to provide your Email address. Then select submit.

- Eligibility
- Claim Status
- Prior Authorization
- Payment History
- Administration**
- User Home
- Change Password
- Web Registration
- Change Provider
- User Administration
- Email/EFT Administration
- NPI Submission
- Reports & Files
- Reports & Data Files

Email/EFT Administration - Edit Information



Please make desired changes to EFT account information below. In addition to EFT information, please include a general email address for your provider organization for receipt of notifications from the Medical Assistance Division.

For newly entered EFT account information, the Begin Date will default to the current date. The Begin Date for new information cannot overlap prior EFT information.

If you need to change existing EFT account information, please change the End Date to yesterday's date, and then click the 'Submit' button. The system will then close the existing EFT account information, and you will be able to enter the new account information.

* denotes required field(s)

EFT Account Information

EFT Status:	New		
EFT Approval Date:			
* Account Type:	<input type="text" value="Checking"/>	* Confirm Account Number:	<input type="text" value="1122233333"/>
* Account Number:	<input type="text" value="1122233333"/>	* Confirm Routing Transit Number:	<input type="text" value="444455556"/>
* Routing Transit Number:	<input type="text" value="444455556"/>	End Date:	<input type="text" value="12/31/9999"/>
Begin Date:	<input type="text" value="07/31/2009"/>		

General Provider Email Address

* Provider Email:	<input type="text" value="anyemail@host.com"/>	* Confirm Provider Email:	<input type="text" value="anyemail@host.com"/>
-------------------	--	---------------------------	--

Submit

Reset

Cancel

IMPORTANT UPDATE!

Electronic Funds Transfers (EFT)

Step four:
Then you will receive a
confirmation.

Eligibility
Claim Status
Prior Authorization
Payment History
Administration
User Home
Change Password
Web Registration
Change Provider
User Administration
Email/EFT Administration
NPI Submission
Reports & Files
Reports & Data Files

Email/EFT Administration - Confirmation

Thank you...

Your EFT account information and/or general provider email address have been successfully updated.

EFT Account Information

EFT Status: Test
EFT Approval Date: 06/10/2009
Account Type: Checking
Account Number: 00000000000000865
Routing Transit Number: 112206459
Begin Date: 06/10/2009 End Date: 12/31/9999

General Provider Email Address

* Provider Email:

REMINDER!

Remittance Advice Update

Registered Web Portal users are no longer mailed an RA. The current RA and newsletter are available on the web portal. The current RA and newsletter are available on the web portal every Monday, along with last 8 RA's. Please download your RA for future reference

Purpose of workshop

Provide information on filling out the CMS-1500 paper claims for:

- Primary Medicaid
- Medicaid secondary to a Third Party Liability (TPL)
- HMO/PP0 copayments
- Medicare replacement plans
- Medicare Crossovers
- Medicaid Tertiary



Eligibility Check List

Date of Service - Make sure client is eligible on DOS

Is the Client Fee for Service, SALUD!, or CoLTS?

Limited Benefits - Check Category of Eligibility

TPL, Medicare, Medicare Replacement Plans -
There may be a payer primary to Medicaid
The client may be required to pay a co-pay



Ways to Check Eligibility

On-Line Eligibility Inquiry—Web Portal
<https://nmmedicaid.acs-inc.com/>

Automatic Voice Response System (AVRS) (505)
246-2219 or (800) 820-6901



Online Eligibility Inquiry

Home | Contact Us | FAQ | Provider Information | Links | HIPAA Information Help | Search | Logout

Org Name: ARROYO CHAMISO PEDIATRIC CENTER Provider ID: 00046433

Eligibility Inquiry

To inquire, enter a Date of Service and Client Inquiry and click 'Submit.'

* denotes required field(s)

* Date of Service: |U/ |Ub |ZUUb

Client Inquiry

Client ID:

Card ID: *Located on front of client's*

SSN: Date of Birth: | | mm dd ccyy

Last Name: First Name: Date of Birth: | | mm dd ccyy

[Online Security](#) | [Browser Compatibility](#) | [Terms of Use](#) | [Privacy Policy](#)
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Build Version: NM-SYST-1.0.050 2006.07.06 - 124



The "SSN-style" ID number



Online Eligibility Inquiry

Eligibility Response

09/13/2007 12:58 PM MDT



Inquiry Criteria

Date of Service: 06/11/2007

Client ID:

For the requested date of service, your inquiry returned the following eligibility information.

Client Information

Client ID:

Client Name:

Date of Birth:

Sex:

Medicaid Card ID:

Recertification Date:

Category of Eligibility Information

COE Code	Benefit Description	COE Add Date	Co-Pay
032	Full Medicaid benefits	05/12/2007	

Lock-In Information

Lock In Type	Provider Name
BEHAVIORAL HLTH STATEWIDE ENT.	VALUEOPTIONS OF NM INC, CSC

Medicare Information

No Medicare information on file for the requested date of service.

Third Party Liability Information

No TPL information on file for the requested date of service.

Long Term Care Information

No long term care information on file for the provider and requested date of service.

Modify Criteria

New Inquiry



Claim Form Requirements

All claims that do not require an attachment for payment must be submitted electronically.

Professional claims are submitted on the 837P electronically and the CMS-1500 on paper.

MAD requires that all paper CMS-1500 claim forms be on the original red claim forms.

Photocopies of claim forms are returned to your billing office.



Electronic Claim Submission

All Fee For Service claims within 90 days from the initial date service that do not require an attachment for payment must be submitted electronically.



Three Ways to Submit Claims Electronically

Payerpath - Free HIPAA Compliant web-based claims entry system.

TIE (Transaction Interface Exchange) - the State of NM's HIPAA translator. If you have software that will generate a HIPAA compliant file you can directly submit the file to NM Medicaid via TIE. TIE is another free service.

Through a Clearinghouse



Three Ways to Submit Claims Electronically

The URL to the registration form for PayerPath submissions and the Trading Partner Agreement to submit to TIE is:

<http://www.hsd.state.nm.us/mad/hipaa.html>

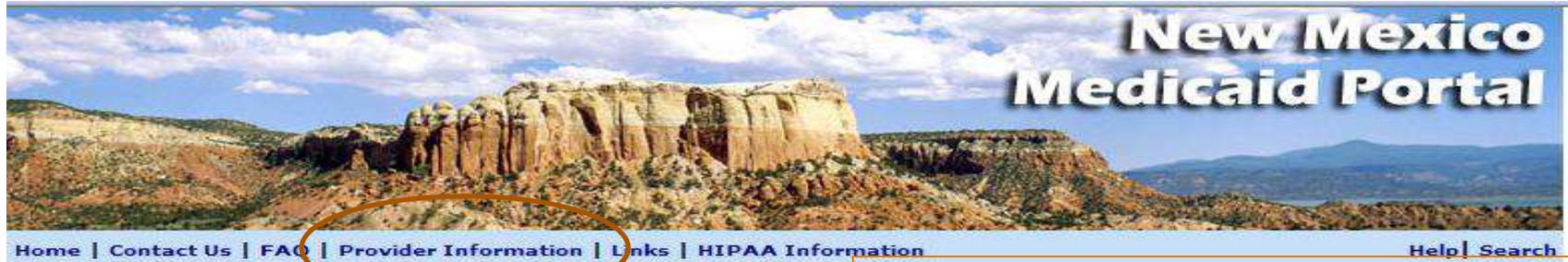
CMS-1500 Claim Submission

The following claim is how a paper CMS-1500 claim form is generally filled out.

You must use procedure codes, etc. that are specific to your claims.



Where to get a copy of claim form instructions



Click on Provider Information

Welcome to the New Mexico Medicaid Portal

The New Mexico Web Portal extends the business capabilities of Medicaid program providers by offering user-friendly tools and resources electronically. Registered users may Log In to access the following interactive features of the portal:

- Claim Status Inquiry
- Prior Authorization Inquiry
- Eligibility Inquiry
- Payment History Inquiry
- Reports and Data Files

Currently enrolled providers can register for portal access using [Web Registration](#). New providers seeking to join the program can download a [Provider Enrollment Packet](#) for step-by-step instructions.

For more information about the web portal or New Mexico Medicaid program, turn to the [FAQ](#), [What's New](#) (updated: 02/27/2008), [Current Remittance Advice Newsletter](#), or [Search](#) functionality.

User Login

User ID:

Password:

[Provider ID or NPI:](#)

[I forgot my password](#)

[I'm a new user \(Web Registration\)](#)

SUBMIT YOUR NPI TO THE NEW MEXICO MEDICAID PROGRAM!

[Click here](#) to submit your NPI to the NM Medicaid fee-for-service Medicaid program. If you have rendering providers affiliated with your billing provider number, you can also submit their NPIs using this web site.

Even if your organization is not registered for web portal access, you can still submit your NPI. But while you're here, you could save time and money by registering your organization to use all the features of the web portal! Go to [Web Registration](#) to get started.

Remember that NPI is required for all healthcare providers. For more information, please see MAD Supplement 07-08: http://www.hsd.state.nm.us/mad/pdf_files/Supplements/M_REG_S_07_08.pdf



Where to get a copy of claim form instructions

Scroll down

Open file

Topic	Word	Adobe
Adjustment/Void Request Form and Instructions - 04/08	Word Format	PDF Format
Claim Inquiry Form - 02/04:	Word Format	PDF Format

Topic	Word	Adobe
CMS-1500 Professional Claim Form	Not Available	PDF Format
UB-04 Institutional Claim Form	Not Available	PDF Format
ADA 2006 Dental Claim Form	Not Available	PDF Format

View these documents with Microsoft Word, PowerPoint, or Adobe Acrobat Reader. Adobe Acrobat Reader must be installed on your computer. If you do not have Acrobat Reader installed, click the icon at right to download this free software.

Medicaid Primary Claim Forms



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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111223333	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia		3. PATIENT'S BIRTH DATE MM DD YY SEX 11 11 90 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		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 ZIP CODE TELEPHONE (Include Area Code) ()	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH SEX		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Doe, John		17a. <input type="checkbox"/> YES <input type="checkbox"/> NO 17b. NPI 1223334444	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			

PATIENT AND INSURED INFORMATION

If a referring provider is required in order to be paid or if you simply wish to enter this information on the claim, enter the referring provider's name in box 17 and the referring provider's NPI in box 17b.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.



19. RESERVED FOR LOCAL USE															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)															
1. 43310			3. 2722			23. PRIOR AUTHORIZATION NUMBER QUALIFIER									
2. 25000			4. _____												
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Category	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER								
05	30	07	05	30	07	11	99214	25	123	78	01	1		ZZ	273R00000X 1234567890
<div style="border: 1px solid orange; padding: 10px; margin: 10px;"> <p>Health care providers: If you are a health care provider, you must submit your NPI. The NPI goes in Box 33a. If the NPI is not submitted, the claim will deny.</p> </div>															
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
Optional			<input type="checkbox"/>		Optional			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 78 01		\$		\$	
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 #					
Required					Situational					Provider Med Gp (505) 333-4444 1234 Rocky Road Mountain View, NM 8888					
SIGNED _____ DATE _____					a. NPI		b. _____		a. 1234567890			b. ZZ363LF0000X			

PHYSICIAN OR SUPPLIER INFORMATION

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

Taxonomy: If you wish to submit rendering provider taxonomy code, it goes in Box 33b preceded by the qualifier "zz".

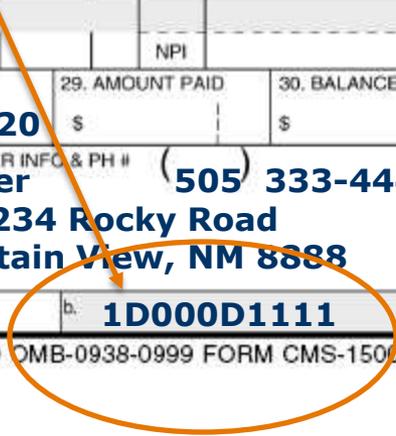
Do not enter a space between the qualifier and the taxonomy code. An example of a correctly submitted taxonomy code is: zz103T00000X.



19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER									
2. _____ 4. _____										12345678X01									
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
From To			MM DD YY MM DD YY			CPT/HCPCS MODIFIER													
1 05 30 07 05 30 07 12						99509 UA					15 20 1				NPI				
<p style="text-align: center;">Non-Health care providers: Legacy Medicaid Number: If you wish to submit your Legacy ID, enter Qualifier 1D directly preceding your Legacy ID Do not enter a space between the qualifier and the Legacy ID.</p>																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
Optional				<input type="checkbox"/>		Optional				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 15 20		\$		\$			
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 Required DATE						Situational						Joe Provider (505) 333-4444 1234 Rocky Road Mountain View, NM 8888							
						a. NPI b.						a. NPI b. 1D000D1111							

PHYSICIAN OR SUPPLIER INFORMATION

If your Medicaid ID is less than 8 digits, enter enough zeroes in front of it to make it 8 digits long.



Timely Filing Denials

Re-filing Claims and Submitting Adjustments

CMS 1500 form: Put the TCN in block 22 on the paper form. Leave the "Code" blank, and put the TCN in the "Original Reference No." field.



Medicaid Third Party Liability (TPL) Claim Forms



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Third Party Liability (TPL) Tips

TPL is commercial insurance

TPL must be billed primary to Medicaid

Medicaid does not consider Medicare TPL



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>							1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111223333	
---	--	--	--	--	--	--	---	--

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia			3. PATIENT'S BIRTH DATE (MM DD YY) SEX 11 11 90 M <input type="checkbox"/> F <input checked="" 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) Patient, Petunia			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER		
--	--	--	---	--	--	---	--	--

a. OTHER INSURED'S POLICY OR GROUP NUMBER 010203			a. INSURED'S DATE OF BIRTH (MM DD YY) SEX _____ M <input type="checkbox"/> F <input type="checkbox"/>		
--	--	--	--	--	--

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX 09 22 90 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME		
---	--	--	-----------------------------------	--	--

c. EMPLOYER'S NAME OR SCHOOL NAME ABC, Inc.			c. INSURANCE PLAN NAME OR PROGRAM NAME		
---	--	--	--	--	--

d. INSURANCE PLAN NAME OR PROGRAM NAME UnitedHealthcare Community Plan			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
--	--	--	-----------------------------	--	--	---	--	--

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					
---	--	--	--	--	--	---	--	--	--	--	--

14. DATE OF CURRENT: MM DD YY			ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(L)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD YY TO MM DD YY		
-------------------------------	--	--	--	--	--	---	--	--	--	--	--

17. NAME OF REFERRING PROVIDER OR OTHER						ON DATES RELATED TO CURRENT SERVICES DD YY TO MM DD YY					
---	--	--	--	--	--	--	--	--	--	--	--

PATIENT AND INSURED INFORMATION

When filling out a Medicaid claim where TPL is primary payer, be sure to fill in all required primary and secondary payer information.



19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES

YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. **65663**

3. _____

2. **V283**

4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER						
1	05	30	07	05	30	07	11		76811	TC	12	400 00	1	ZZ	273R0000X NPI 1234567890	
2	05	30	07	05	30	07	11		76820	TC	12	170 00	1		NPI	
3	<div style="border: 1px solid orange; padding: 5px; display: inline-block; margin-right: 20px;"> Attach a copy of the EOB along with the explanation of denials page </div> <div style="border: 1px solid orange; padding: 5px; display: inline-block;"> Always enter the amount the insurance has paid in Box 29 on the CMS-1500. </div>															
4																
5																
6										X					NPI	

25. FEDERAL TAX I.D. NUMBER Optional		SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 570 00		29. AMOUNT PAID \$ 120 00		30. BALANCE DUE \$ 450 00	
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.) Required				32. SERVICE FACILITY LOCATION INFORMATION Situational				33. BILLING PROVIDER INFO & PH # Provider Med Gp 505 333-4444 1234 Rocky Road Mountain View, NM 8888					
SIGNED _____ DATE _____				a. NPI		b. _____		a. 1234567890		b. ZZ363LF0000X			

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



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PHYSICIAN OR SUPPLIER INFORMATION

Medicaid HMO/PPO Copayment Claim Forms



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HMO Co-Pay Tips

Write "HMO Co-pay Due" on the claim. Attach the EOB.

In the "amount paid" field (Box 29), enter the difference between the billed amount and the co-payment.

Enter the co-payment amount in the "est. amount due" field (Box 30).



1500 HMO CO-PAY DUE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Write "HMO Co-pay Due" in the upper left hand side of the claim form next to the "1500" and attach the EOB.

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111223333	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia		3. PATIENT'S BIRTH DATE MM DD YY SEX 11 11 1990 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 010203		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> 09 22 90		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME ABC, Inc.		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME UnitedHealthcare Community Plan		10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	

PATIENT AND INSURED INFORMATION



19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					\$ CHARGES																			
21. DIAGNOSIS OR NATURE OF ILLNESS 1. 65663 2. V283										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																								
23. PRIOR AUTHORIZATION NUMBER										F. \$ CHARGES					G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER																
1 05 30 07 05 30 07 11										11		76811 TC				12		400 00 1		ZZ		273R0000X 1234567890												
2 05 30 07 05 30 07 11										11		76820 TC				12		170 00 1		NPI														
3																		NPI																
4																																		
5																																		
6																																		
25. FEDERAL TAX I.D. NUMBER Optional					SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. Optional					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 570 00					29. AMOUNT PAID \$ 520 00					30. BALANCE DUE \$ 50 00				
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.) Required										32. SERVICE FACILITY LOCATION INFORMATION Situational										33. BILLING PROVIDER INFO & PH # Provider Med Gp 505 333-4444 1234 Rocky Road Mountain View, NM 8888														
SIGNED					DATE					a. NPI					b. 1234567890					b. ZZ363LF0000X														

Attach a copy of the EOB along with the explanation of denials page

In the "amount paid" field, enter the difference between the billed amount and the co-payment.
Enter the co-payment amount in the "balance due" field.

PHYSICIAN OR SUPPLIER INFORMATION



Medicare Replacement Plan Claim Forms



A **xerox**  Company

Medicare Replacement Plan (MRP) Claim Tips

Write "Medicare Replacement Plan Only" on the claim. Attach the EOB.

In the "amount paid" field (BOX 29), enter the difference between the billed amount and the co-payment.

Enter the co-payment amount in the "est. amount due" field (Box 30).



1500

MEDICARE REPLACEMENT PLAN

Write "Medicare Replacement Plan" in the upper left hand side of the claim form next to the "1500". Attach the EOB.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111223333	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia		3. PATIENT'S BIRTH DATE MM DD YY 11 11 1990 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
c. EMPLOYER'S NAME OR SCHOOL NAME		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		c. INSURANCE PLAN NAME OR PROGRAM NAME	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		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 _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17b. NPI _____			



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19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILL 1. 65663 2. V283										22. RENDERING TAXONOMY/NPI 273R00000X QUALIFIER NUMBER ZZ RENDERING PROVIDER ID. # 1234567890									
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER												
1	05	30	07	05	30	07	11	76811	TC		12	400	00	1			ZZ	273R00000X	1234567890
2	05	30	07	05	30	07	11	76820	TC		12	170	00	1					
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
Optional				<input type="checkbox"/>		Optional				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 570 00		\$ 120 00		\$ 450 00			
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 #							
Required						Situational						Provider Med Gp (505) 333-4444 1234 Rocky Road Mountain View, NM 8888							
SIGNED		Required				DATE		a. NPI		b. 1234567890		c. ZZ363LF0000X		d. TAXONOMY					

Attach a copy of the EOB along with the explanation of denials page

Rendering TAXONOMY/NPI

QUALIFIER

In the "amount paid" field, enter the difference between the billed amount and the co-payment.
Enter the co-payment amount in the "net due" field.

BILLING PROVIDER'S NPI

TAXONOMY

(TAXONOMY IS NOT REQUIRED FOR RENDERING PROVIDER)



Medicare Primary Claim Forms (Crossovers)



A **xerox**  Company

Medicare Primary Claims (Crossovers)

When billing for clients covered by Medicare for which Medicare has paid something on the claim and the claim DID NOT automatically crossover from Medicare to ACS, submit those claims via paper to ACS with the Medicare EOMB attached.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111223333	
---	--	--	--	--	--	---	--

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia			3. PATIENT'S BIRTH DATE MM DD YY SEX 11 11 1990 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
--	--	--	--	--	---	--

5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
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NM Medicaid does not consider Medicare to be TPL, so be certain that you do not fill in any of the TPL information blocks.

CITY						
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ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)	
()		()		()		()	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER		
---	--	--	--	--	--	---	--	--

a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH MM DD YY SEX		
---	--	--	--------------------------------------	--	--	---	--	--

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX			b. AUTO ACCIDENT? PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
---	--	--	---------------------------------	--	--	-----------------------------------	--	--

c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME		
-----------------------------------	--	--	--------------------	--	--	--	--	--

d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
--	--	--	-----------------------------	--	--	--	--	--

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					
---	--	--	--	--	--	---	--	--	--	--	--

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
---	--	--	--	--	--	--	--	--	--	--	--

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
			17b. NPI _____								



CARRIER
PATIENT AND INSURED INFORMATION

19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					\$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 7213										22. MEDICAID RESUBMISSION CODE					ORIGINAL REF. NO.				
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER									
2. _____ 4. _____																			
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER											
1	05	30	07	05	30	07	24		64483	RT			1	1683	00	1		NPI	
2	05	30	07	05	30	07	24		64484	RT			1	906	00	1		NPI	
3	Attach a copy of the EOMB along with the explanation of denials page										Don't fill out boxes 29 and 30. We'll key this info directly from the EOMB.								
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE			
Optional				<input type="checkbox"/>		Optional				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 2589 00		\$		\$			
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 #							
Required						Situational						Provider Med Gp 505 333-4444 1234 Rocky Road Mountain View, NM 8888							
SIGNED		DATE				a. NPI		b.		a. 1234567890			b. ZZ273R0000X						

PHYSICIAN OR SUPPLIER INFORMATION



Medicaid Tertiary Claim Forms



A **xerox**  Company

Medicaid Tertiary Claims

Medicaid tertiary claims are submitted in the following order:

- Medicare primary
- TPL secondary
- Medicaid tertiary



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>							1a. INSURED'S I.D. NUMBER (For Program in Item 1) 111223333	
---	--	--	--	--	--	--	---	--

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia			3. PATIENT'S BIRTH DATE (MM DD YY) SEX 11 11 1990 M <input type="checkbox"/> F <input checked="" 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)	
------------------------------------	--	--	---	--	------------------------------------	--

8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE
--	--	--	------	--	-------

ZIP CODE		TELEPHONE (Include Area Code) ()			
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Patient, Petunia					
--	--	--	--	--	--

a. OTHER INSURED'S POLICY OR GROUP NUMBER 010203			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER
--	--	--	--	--	---

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX 09 22 90 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
---	--	--	---	--	--

c. EMPLOYER'S NAME OR SCHOOL NAME ABC, Inc.			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME
---	--	--	--	--	-----------------------------------

d. INSURANCE PLAN NAME OR PROGRAM NAME UnitedHealthcare Community Plan			10d. RESERVED FOR LOCAL USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
--	--	--	-----------------------------	--	--

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>
---	--	--	--	--	--	---

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 _____					
---	--	--	--	--	--

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
--	--	---	--	---	--

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
--	--	--	------	--	--

17b. NPI			17b.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
----------	--	--	------	--	--

Fill out the TPL information



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

a. OTHER INSURED'S POLICY OR GROUP NUMBER
010203

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX
09 22 90 M F

c. EMPLOYER'S NAME OR SCHOOL NAME
ABC, Inc.

d. INSURANCE PLAN NAME OR PROGRAM NAME
UnitedHealthcare Community Plan

CARRIER

PATIENT AND INSURED INFORMATION



19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 7213										22. MEDICAID RESUBMISSION CODE				ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
1	05		30		07		05		30		07		24	64483		RT		1	1683 00		1		NPI
2	05		30		07		05		30		07		24	64484		RT		1	906 00		1		NPI
3																							NPI
4																							NPI
5																							NPI
6																							NPI
25. FEDERAL TAX I.D. NUMBER Optional				SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. Optional				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2589 00		29. AMOUNT PAID \$ 640 00		30. BALANCE DUE \$ 1949 00							
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.) Required						32. SERVICE FACILITY LOCATION INFORMATION Situational						33. BILLING PROVIDER INFO & PH # Provider Med Gp 505 333-4444 1234 Rocky Road Mountain View, NM 8888											
SIGNED		DATE				a. NPI		b.		a. 1234567890		b. ZZ273R0000X											

Fill out claim form as if you were billing secondary to a TPL.

Attach a copy of the Medicare EOMB and the TPL EOB, along with the explanation of denials page. The claim must match the EOBs

Only amount paid by TPL is entered in box 29. Medicare payment is keyed directly from EOMB.

PHYSICIAN OR SUPPLIER INFORMATION

Did you remember to?

Ensure the line item charges are correct and match the total charge.

If you're a for profit organization, make sure gross receipts tax is included in the line items, if applicable.

Procedure and diagnosis codes are entered correctly
Sign and date the claim.



Did you remember to?

Include your NPI or provider number.

Include all appropriate EOB's for TPL, HMO, Medicare, etc.

Attach proof of timely filing/TCN if needed.

Keep a copy of the correspondence for your records.





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