Detailed Guidance On HCFA 1500 Claim Form Completion

Claims Filing Tips

Claim forms that are submitted with incomplete or incorrect information hinder timely claims payment. Your office can expedite claims resolution by submitting claims that are filled out correctly and completely. Please see the following tips for completing and submitting the HCFA 1500 Claim Form.

- All blocks on the claim form(s) must be accurately completed to permit timely claims processing.
- When billing TRICARE as a secondary payer, you must include an Explanation of Benefits (EOB) from the primary carrier.
- Contact your Provider Relations Representative with any changes to your Tax Identification Number (TIN) or address information immediately. Any change in your information requires action within PGBA's computer system to ensure proper processing and accounting for your facility.

Inside is a more detailed guidance for specified areas of the HCFA 1500 claim form.

Important Phone Numbers/Addresses

Puerto Rico Call Center
Humana Military Healthcare Services
PO Box 195519
San Juan, PR 00919
(800) 700-7104

Claims Submissions
TRICARE Puerto Rico
PO Box 7035
Camden, SC 29020-7035
www.humana-military.com

Guidance on HCFA 1500 Claim Form Completion

HCFA Field #1-A – INSURED'S ID NUMBER
Make sure that you enter the sponsor's 9-digit Social Security Number. All eligibility information and processing depends upon the correct name and Social Security Number of the sponsor or "insured." We recommend that you keep A copy of the patient identification card (front and back) in your file for reference purposes. It provides the sponsor's identifying information, as well as eligibility information on the individual patient.

HCFA Field #4 – INSURED'S NAME
The name of the person in whose name the insurance is carried. For TRICARE submissions, the insured will always be the Military sponsor.

HCFA Field #9 – OTHER INSURED'S NAME
Enter the name of the TRICARE beneficiary who is insured by primary health insurance (OHI) in Field #9. Make sure that fields 9A-9D are answered. Field 9D, "Insurance Plan Name" is especially important. Information on supplemental insurance policies should not be included here.

HCFA Field #10-B and C
If the patient's condition or injury resulted from an accident, you must include details of the accident to assist in processing the claim through subrogation or third party liability process. Include information such as when, where and how the accident occurred.

HCFA Field #11-D – HEALTH
BENEFIT PLAN?
Field #11-D cannot be left blank and must be checked "YES" (if the patient has coverage which is primary to TRICARE) or "NO" (if the patient truly has no other health insurance or only a TRICARE supplement). Note: If the patient has other health insurance through work, a private policy or entitlement, that insurance must be billed and adjudicated before submission to PGBA. An Explanation of Benefits from the primary carrier must be included with the claim submitted for TRICARE benefits.

HCFA Field #17 – REFERRING PHYSICIAN
When billing for a consultation, you must include the referring physician's name or Tax Identification Number in this field.

HCFA Field #21
Enter diagnosis codes on lines 1,2,3 and 4, using the International Classification of Diseases, Ninth Revision (ICD-9-CM). These codes are updated annually and sometimes require a 4th or 5th digit to process correctly. Each code must agree with the patients age and sex, and with the procedure performed.

HCFA Field #23 –
PREAUTHORIZATION NUMBER
Failure to obtain required preauthorization will result in a denial to the provider.

HCFA Field #24D – PROCEDURES, SERVICES OR SUPPLIES
Describe service(s) rendered to patient, using the American Medical Association's current Physician's Current Procedural Terminology, CPT coding, including a written description. Ambulance, DME, and Home IV Therapy should be billed using HCPC codes (HCFA Common Procedure Codes). These codes are updated annually and may require detailed medical records. Each code must agree with the patients age and sex, and with the diagnosis submitted. When a piece of equipment is rented, please indicate with the modifier "RR."

HCFA Field #25 – FEDERAL TAX ID NUMBER
Include the proper TAX ID Number on each claim. If you maintain two or more offices, and you know the three digit suffix for each "satellite" office, you can improve both the speed and accuracy of your claims resolution by adding the correct suffix onto your Tax Identification Number (TIN).

HCFA Field #27 – ACCEPT ASSIGNMENT?
Network providers must accept assignment on every claim. Reimbursement is not to be collected up front from the beneficiary for covered services. Your payment is based on your negotiated contract rate and you will receive payments from TRICARE.

HCFA Field #31 – SIGNATURE OF PHYSICIAN OR SUPPLIER
The name of the rendering (or "hands on") provider is required on all HCFA 1500 forms. This information can be placed in either Field #24-K or Field #31. Although it is only necessary to identify the physician or supplier by name, you can facilitate faster claim processing by including the rendering provider's Social Security Number as well. Make sure the first name, last name, and title and included and legible

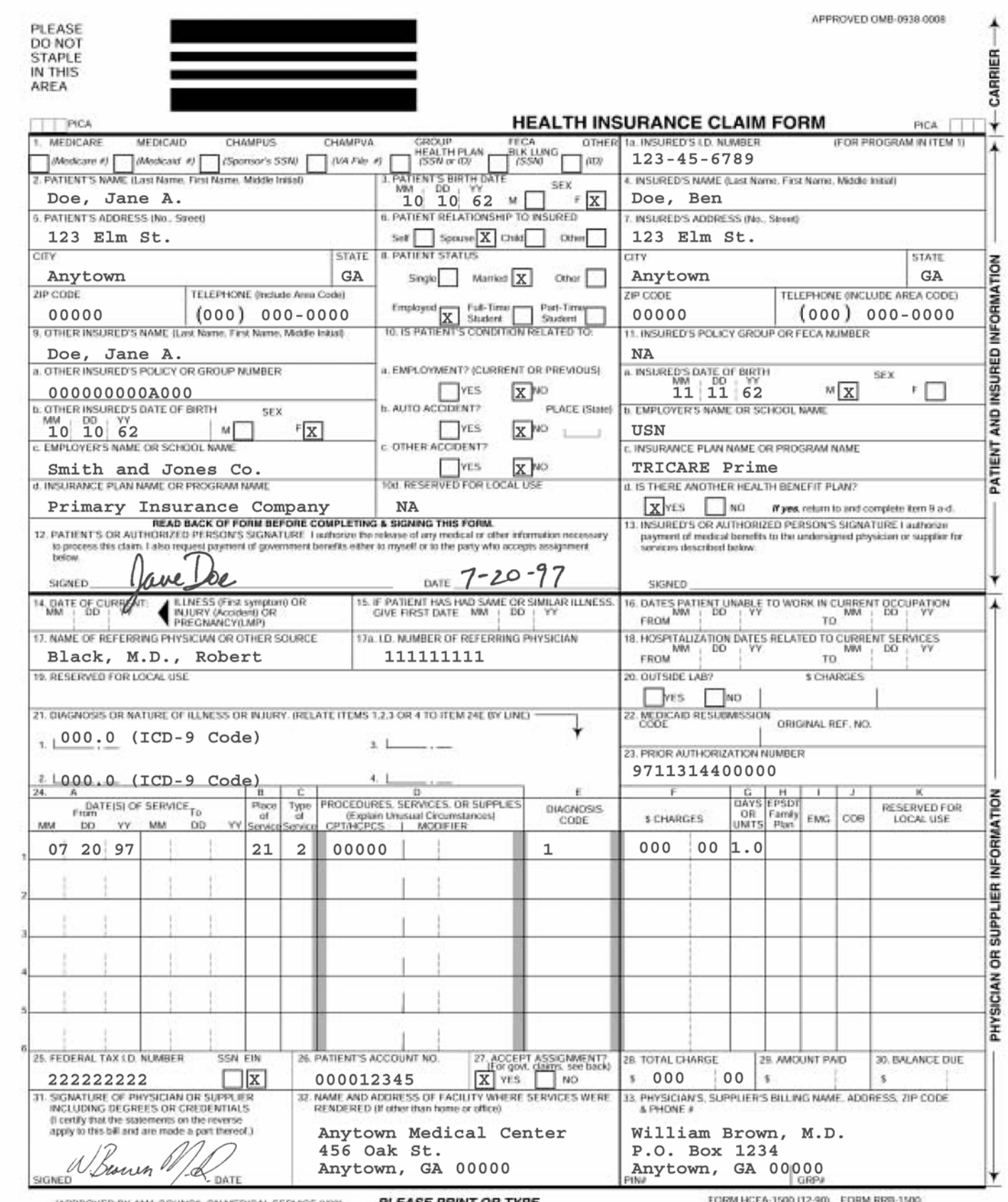
Guidance on HCFA 1500 Claim Form Completion

HCFA Field #32 – NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

Field #32 must be used to identify the physical address of the site where services were rendered. This field is required to complete claims processing.

HCFA Field # 33 – PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE NUMBER

Field #33 should identify the provider's billing or "pay to" address where payment should be sent.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123-45-6789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A.

3. PATIENT'S BIRTH DATE: 10 10 62 | SEX: M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Elm St.

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

7. INSURED'S ADDRESS (No., Street): 123 Elm St.

CITY: Anytown | STATE: GA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: Anytown | STATE: GA

ZIP CODE: 00000 | TELEPHONE (Include Area Code): (000) 000-0000

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 00000 | TELEPHONE (INCLUDE AREA CODE): (000) 000-0000

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A.

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NA

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 000000000A000

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 11 11 62 | SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: 10 10 62 | SEX: M [ ] F [X]

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

b. EMPLOYER'S NAME OR SCHOOL NAME: USN

c. EMPLOYER'S NAME OR SCHOOL NAME: Smith and Jones Co.

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: TRICARE Prime

d. INSURANCE PLAN NAME OR PROGRAM NAME: Primary Insurance Company

10d. RESERVED FOR LOCAL USE: NA

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

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: Jane Doe | DATE: 7-20-97

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)

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Black, M.D., Robert

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 111111111

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 000.0 (ICD-9 Code)
2. 000.0 (ICD-9 Code)
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 9711314400000

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 20 97		21	2	00000		1	000 00	1.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 222222222 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 000012345

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

28. TOTAL CHARGE: $ 000 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: W Brown M.D. DATE:

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Anytown Medical Center
456 Oak St.
Anytown, GA 00000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

William Brown, M.D.
P.O. Box 1234
Anytown, GA 00000

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500