Claim Requirements and Dispute Guidelines

General Guidelines

Tufts Health Plan processes completed claims that meet the conditions of payment and that are submitted within the time frame identified in your agreement with Tufts Health Plan. Completed claims are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately (see Claim Specifications section in this chapter). Claims must be submitted within the contracted filing deadline according to the date of service, date of discharge, or date of the primary insurance carrier's explanation of benefits (EOB). Tufts Health Plan Medicare Preferred will deny claims submitted after the filing deadline, and the member is not responsible for payment. See Filing Deadline section of this chapter and Claims Submission Payment Policy for more information.

Additional guidelines, payment policies, and clinical coverage criteria for specific services are available on the Tufts Health Plan website. To ensure accurate claims processing, it is recommended that providers refer to the Payment Policies on our website. For initial claims submission and additional information, see the Tufts Health Plan Claims Submission Policy and tips for Avoiding Administrative Claim Denials.

Electronic Data Interchange Claims

Tufts Health Plan encourages direct electronic submission to the plan, but also accepts claims submitted via a clearinghouse or MD On-Line[1]. Claims submitted directly to Tufts Health Plan Medicare Preferred must be in HIPAA-compliant standard 837 format and include all required information to be accepted. Refer to 837 Companion Guide for additional information. All methods of EDI claim submission produce claim reports that can be accessed electronically. These reports are used to confirm the receipt of claims as well as follow up on rejected claims.

When required information is missing, Tufts Health Plan Medicare Preferred or the clearinghouse will reject the claim. If an electronic claim is rejected, resubmit a clean electronic claim no later than 60 days from the date of service. For additional information, refer to our Claims Submission Policy and Avoiding EDI Claim Rejections.

For more information about submitting electronic transactions, contact Tufts Health Plan's EDI Operations Department via email at EDI_operations@tufts-health.com or by phone at 888.880.8699, ext. 54042 for a set-up request. You can also visit the Electronic Services section of our website to download a set-up form and companion documents for submitting claims electronically directly to Tufts Health Plan Medicare Preferred.

[1] Professional claims only.

EDI Referrals, Eligibility and Claim Status Inquiry

EDI submission commonly refers to claims, referral and eligibility transactions, but can be applied to other transaction types as well. Tufts Health Plan offers options for electronic referrals, online eligibility inquiries and claim status information, as follows:

Referral	• Web-based referral inquiry via the Tufts Health Plan Provider Login • ANSI 278: Request for Review and Response for outpatient referrals — standardized referral submission format, currently available through NEHEN
Eligibility	• Web-based eligibility status via the Tufts Health Plan Provider Login • Status information via Emdeon POS Device: facilities data input and status retrieval • NEHEN Eligibility Inquiry and Response • IVR (Integrated Voice Response) at 888.884.2404
Claim Status Inquiry	• Web-based claims inquiry via the Tufts Health Plan Provider Login • NEHEN

Multiple Payees

For providers billing through EDI, Tufts Health Plan cannot accommodate payment to multiple payees at multiple payment addresses. Payment will be sent to the address listed as the primary provider's office location in the Tufts Medicare Preferred HMO provider database. Any address changes or primary vendor/payee changes should be submitted in writing to the Tufts Health Plan Provider Information Department.

Paper Claims

We are not able to accept claim attachments electronically. Industry-standard paper claim forms should be submitted for the following instances:

- Claims requiring additional supporting documentation, such as operative or medical notes
- Claims for provider payment disputes
- Unlisted CPT procedures that require explanations or descriptions

Paper Claim Submission Requirements

All paper CMS 1500 and UB-04 claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied versions, faxed versions and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning, will not be accepted and will be returned with a request to submit on the proper claim form.

To avoid a filing deadline denial, rejected paper claims must be submitted within 60 days from the date of service for professional or outpatient services or within 60 days from the date of discharge.

Submitted paper claim forms should include all mandatory fields as noted in the Claim Specifications section of this chapter. Paper claim forms deemed incomplete will be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

- Industry-standard codes should be submitted on all paper claims.
- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include but are not limited to the following:
  - Illegible claim forms
  - Member ID number
  - Date of service or admission date
  - Physician's signature (CMS-1500 Box 31)

Paper claims should be mailed to the following address:

Tufts Health Plan Medicare Preferred
P.O. Box 9183
Watertown, MA 02471-9183

Claims Payment

Clean Claims

Medicare defines a clean claim as a claim that does not require the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the filing period.

For information about the forms to use for submitting claims, see Claim Specifications section in this chapter.

To qualify for payment, clean claims must also meet the following Conditions of Payment:

- The billed services must be:
  - Covered in accordance with the applicable benefit document provided to Tufts Medicare Preferred HMO members who meet eligibility criteria and are Members on the date of service
  - Furnished by a provider eligible for payment under Medicare
  - Provided or authorized by the member's PCP or the PCP's covering provider in accordance with the applicable benefit document, or as identified elsewhere in your agreement with Tufts Health Plan (if applicable)
  - Provided in the member's Evidence of Coverage document
  - Medically necessary as defined in the Medicare coverage guidelines
- Tufts Health Plan received the claim within 60 days from the date of service or the date of discharge if the member was inpatient, or date of the primary insurance carrier's explanation of benefits (EOB).
- The services were preregistered and/or prior authorized in accordance with Tufts Medicare Preferred HMO's preregistration and precertification procedures.
- The services were billed using the appropriate CPT codes and/or HCPCS codes.
- In the case of professional services billed by the hospital, services were billed electronically according to the HIPAA standard or on CMS-1500 and/or UB-04 forms with a valid CPT code and/or HCPCS code.

All services rendered to Tufts Medicare Preferred HMO members must be reported to Tufts Health Plan as claims data. Claim forms are submitted by providers for both payment and tracking purposes.

All services rendered to Tufts Medicare Preferred HMO members must be reported to Tufts Health Plan Medicare Preferred as *encounter* or *claims* data. An *encounter* is a billing form submitted by capitated providers for tracking purposes. *Claim* forms are submitted by noncapitated providers for both payment and tracking purposes.

Explanation of Payment (EOP)

The Tufts Medicare Preferred HMO Explanation of Payment (EOP) is a weekly report of all claims that have been paid, pended, or denied to that provider. Your EOP will also include a summary of claims in process. This summary indicates the claims that Tufts Health Plan has received, however, may require additional review or information before being finalized in the system. The EOP for capitated providers shows zero dollars paid, and the pay code indicates that services were prepaid under the capitation agreement. The EOP for noncapitated providers indicates the amount paid, denied or pended, with a message code indicating the claim status.

EOPs can be viewed electronically by logging on to the PaySpan Health website and electronic versions of EOPs are available for download and printing on the PaySpan website.

Summary of Claims in Process

Tufts Health Plan generates a weekly Summary of Claims in Process report that shows all claims received to date and pending for payment. The Summary of Claims in Process reports looks like the Explanation of Payment (EOP) reports, except "Summary of Claims in Process" appears at the top of the barred section, and pay codes display a pending message rather than a payment or denial message.

All entries on the Summary of Claims in Process appear on the EOP when adjudicated.

Electronic Remittance Advice

Upon request, Tufts Health Plan offers the HIPAA Standard 835 Health Care Claim Payment/Advice Transaction. This electronic remittance advice (ERA) includes paid and denied claims submitted via EDI or on paper forms and uses HIPAA standards reason codes.

Providers interested in receiving the ERA should contact EDI Operations:

- Via e-mail at EDI_operations@tufts-health.com
- By calling 888.880.8699 x54042

See Tufts Health Plan's HIPAA 835 Companion Guide for information about the HIPAA standard 835 transaction.

Claims Reports

Tufts Health Plan Medicare Preferred sends the following reports to medical groups regarding claims for patients in their group:

A **Weekly Referral Report** includes claims for which Tufts Health Plan has not received a referral. The report gives the PCP an opportunity to authorize or deny the payment of billed services. The group has 10 business days from the date of the letter that accompanies the report to respond with a pay or deny response. The Notice of Attestation of Authorization and Denial of Payment must accompany the returned report and must include a valid reason for a denial. The form must be signed and dated by the Member's PCP, a covering provider, or the medical director. Note that a stamped signature is not appropriate. After 10 business days, any claims for which a response is not received are considered authorized.

• The biweekly **Adjusted Claims Report** includes claims that Tufts Health Plan has retracted and reprocessed. Medical groups can then review claims that have been adjusted for denial or payment.

• Two **Paid Claims Reports** are generated biweekly and show claims processed from the Medical Services Fund and those processed from the Hospital Services Fund. These reports allow the medical group to review claims processed from each service fund.

Corrected Claims

Tufts Health Plan accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), the Medicare Managed Care Manual, and HIPAA EDI standards for Tufts Medicare Preferred HMO claims.

Electronic Submissions

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either "7" (corrected claim), "5" (late charges), or "8" (void or cancel a prior claim).
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter REF*F8*23456789.

Note: Provider payment disputes that require additional documentation must be submitted on paper.

Paper Submissions

Disputes (not corrected claims) must include a completed Provider Request for Claim Review Form. Both corrected claims and disputes, however, should be mailed to the address on the form.

For a corrected **facility** claim:

- On the UB-04 (CMS-1450) form, enter either "7" (corrected claim), "5" (late charges), or "8" (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill), and enter the original claim number in Box 64 (Document Control Number).

For a **corrected** professional claim:

- In Box 22 (Medicaid Resubmission Code) on the CMS-1500 form, enter the frequency code "7" under "Code" and the original claim number in the same box under "Original Ref No."

Filing Deadline

Filing Deadline Policy

Tufts Health Plan follows the guidelines described in the Tufts Health Plan Claims Submission Policy. For professional or outpatient services, Tufts Health Plan must receive claims within 60 days from the date of service for Tufts Medicare Preferred HMO claims. For inpatient or institutional services, Tufts Health Plan must receive claims within 60 days from the date of hospital discharge. When a member has multiple insurance plans, the filing deadline for claims submission is 60 days from the date of the primary insurer's explanation of benefits (EOB).

Filing Deadline Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing deadline must be submitted within 120 days of the EOB date on which the claim originally denied. Disputes received after 120 days will not be considered.

If the initial claim submission is after the filing deadline and the circumstances for the late submission are beyond the provider's control, the provider may submit a payment dispute for reconsideration by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing deadline and any supporting documentation.

Documented proof of timely submission must be submitted with any request for review and payment of a claim previously denied due to the filing deadline. A completed Provider Request for Claim Review Form must also be sent with the request.

For paper claim submissions, the following are considered acceptable proof of timely submission:

- Copy of patient ledger that shows the date the claim was submitted to Tufts Health Plan.
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim.
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify him/herself as a Tufts Medicare Preferred HMO member at the time of service.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted though a clearinghouse or MD On-Line, a copy of the transmission report and rejection report showing that the claim did not reject at the clearinghouse or at Tufts Health Plan (two separate reports).
- For claims submitted directly to Tufts Health Plan, the corresponding report showing that the claim did not reject at Tufts Health Plan
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify him/herself as a Tufts Medicare Preferred HMO member at the time of service

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- Verbal requests

Requests for filing deadline adjustments for Tufts Medicare Preferred HMO claims should be sent to the following address:

Tufts Medicare Preferred HMO
Provider Payment Disputes
P.O. Box 9162
Watertown, MA 02471-9162

Provider Disputes

Providers who disagree with the reimbursement, adjudication or denial of a Tufts Medicare Preferred HMO claim can submit a payment dispute to:

Tufts Medicare Preferred HMO
Provider Payment Disputes
P.O. Box 9162
Watertown, MA 02471-9162

Payment disputes must include a copy of the EOP, appropriate documentation, and a completed Provider Request for Claim Review Form. For more information on the dispute process, see the Tufts Health Plan Provider Payment Dispute Policy.

Note: Payment disputes cannot be submitted via Electronic Data Interchange (EDI). However, corrected claims may be submitted via EDI using the frequency code.

Coordination of Benefits

Members may have private health insurance that takes precedence over their Tufts Medicare Preferred HMO coverage. Tufts Medicare Preferred HMO providers should observe the following rules to determine which plan has the primary obligation to provide benefits:

- If the patient is covered by more than one health plan at the time of service and Tufts Health Plan is the secondary insurer, do not take a cost-sharing amount up front. Submit the claim to the private carrier as the primary insurer, then submit the claim with the primary insurer's explanation of benefits (EOB) to the secondary insurer (Tufts Health Plan).
- If a cost-sharing amount is due, it will appear on your EOP at the time of payment, and you may then bill the patient. Whether Tufts Health Plan is the primary or secondary insurer, the member must follow plan procedures to receive benefits.
- If a claim is submitted stating that other coverage exists, the corrected claim must also be submitted. Submit the claim no more than 60 days after the EOB is received. Tufts Health Plan is responsible for identifying and coordinating benefits.

For additional information, refer to the Coordination of Benefits Policy on our website. Questions regarding coordination of benefits may be directed to the Tufts Health Plan COB Department at 617.972.1098.

Filing Deadline for Coordination of Benefits Claims

The filing deadline for claims submission in the case of multiple insurance carriers is 60 days from the date of the primary insurer's explanation of benefits (EOB). The EOB from the primary insurer must be submitted with the claim when Tufts Medicare Preferred HMO is the secondary payer.

Coordination of Benefits Adjustments

If submitting for coordination of benefits (COB) adjustments, send a copy of the EOP with the primary carrier's EOB and the Provider Payment Dispute Form. The original claim will be adjusted accordingly.

Subrogation

Subrogation is another liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or his insurer). In some instances, Tufts Health Plan has the right to recover the value of services provided to Members for which a third party is responsible.

Tufts Health Plan has outsourced subrogation recovery services to the Rawlings Company in La Grange, KY, and as a result you may receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries related to such claims should be directed to the Rawlings Company representative at the number indicated on the correspondence. All other subrogation questions should be directed to the Provider Relations Department at 800.279.9022.

Note: Do not bill the member or the member's attorney directly even if you are requested to do so by either of them. If you choose to bill the member or attorney directly, you do so at your own risk.

Motor Vehicle Accidents (No-Fault or PIP Coverage)

Tufts Health Plan coordinates with no-fault auto insurance coverage Personal Injury Protection (PIP) and/or Medical Payment (Medpay) on claims for services rendered as a result of a motor vehicle accident (MVA). Members should not be billed or required to pay up front for services as a result of a MVA, other than applicable cost-sharing amounts. For motor vehicle accident claims, providers should bill the motor vehicle carrier directly. The no-fault auto insurance coverage is primary for the full PIP coverage and/or any available MedPay coverage.

After receiving the insurer's statement or check, if further payment is requested for a Tufts Medicare Preferred HMO member, providers must bill Tufts Health Plan within the 60-day filing deadline date from the date the statement or check was issued.

Note: Under your Tufts Medicare Preferred HMO contract, once the member's PIP and MedPay benefits are exhausted, you cannot balance bill the member or file a lien against the member's third party settlement or judgment. For more information, refer to the Motor Vehicle Accident Payment Policy on our website. For questions regarding third-party liability, contact the Rawlings Company at 502.587.1279.

Claim Specifications

Completing the UB-04 Form

Use the UB-04 form to complete a Medicare claim for institutional services. To complete this form, refer to the instructions in UB-04 Claim Form Specifications in this chapter. Field information is required unless otherwise noted. This form may be prepared according to Medicare guidelines as long as all required fields are completed.

Completing the CMS-1500 (02/12) Form

Use the CMS-1500 (02/12) form to submit a Medicare claim for non-institutional services. All providers, including internal medicine, gynecology and psychiatry, should use ICD-CM diagnosis codes and HCPCS/CPT procedure codes. Oral surgeons may use CDT-3 codes, and dentists may use the ADA procedure codes and ADA form. To complete this form, refer to the instructions in CMS-1500 (02/12) Claim Form Specifications section.

Note: If unlisted or miscellaneous codes are used, notes and/or a description of services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

UB-04 Claim Form Specifications

Box	Field Name	Instructions
1	Untitled	Enter the name and payment address of the hospital/provider.
2	Untitled	Enter the address of the payee if different from the address in Box #1.
3 a-b	Patient Control Number	• 3a: Enter the patient account number as assigned by the hospital. • 3b: Enter the medical record number.
4	Type of Bill	Enter the 3-digit code to indicate the type of bill submitted.
5	Federal Tax Number	Enter the hospital/provider's federal tax ID number.
6	Statement Covers Period	• Enter the beginning and ending services dates for the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the FROM and THROUGH dates will be the same. • If the FROM and THROUGH dates differ, Tufts Health Plan SCO requires these services to be itemized by date of service (refer to Box #45).
7	Untitled	Not applicable.
8 a-b	Patient Name	• 8a: Enter patient ID number. • 8b: Enter the patient's last name, first name and middle initial, if any, as shown on the patient's Tufts Health Plan SCO identification card.
9 a-e	Patient Address	Enter the patient's mailing address from the patient record.
10	Birthdate	Enter the patient's date of birth (MMDDYY).
11	Sex	Enter **M** or **F**.
12	Admission Date	Enter the date of this admission/visit.
13	Admission Hour (HR)	Enter the time of this admission/visit.
14	Admission Type	Enter the code indicating the type of this admission/visit.
15	Admission Source (SRC)	Enter the code indicating the source of this admission/visit.
16	Discharge Hour (DHR)	Enter the time the patient was discharged.
17	Patient Discharge Status (STAT)	Enter the code to indicate the status of the patient as of the THROUGH date on this billing (Box #6).
18-28	Condition Codes	Enter the code used to identify conditions relating to this bill that can affect payer processing.
29	Accident (ACDT) State	Enter the state in which an auto accident occurred, if applicable.
30	Untitled	Not applicable.
31-34	Occurrence Codes and Dates	Enter the code and associated date defining a significant event relating to this bill that may affect payer processing. **Note:** Tufts Health Plan requires reporting of all accident-related occurrence codes.
35-36	Occurrence Span: Codes and Dates	Enter a code and the associated dates that identify an event that relates to the payment of the claim.
37	Untitled	Not applicable.
38	Untitled	Not applicable.
39-41	Value Codes and Amounts	Not applicable.
42	Revenue (REV) Codes	Enter the most current uniform billing revenue codes.

Box	Field Name	Instructions
43	Revenue Description	• Enter a narrative description of the services/procedures rendered. • Whenever possible, use CPT-4/HCPCS definitions.
44	HCPCS/Rates	• For outpatient services, use CPT and HCPCS Level II codes for procedures, services and supplies. • Do not use unlisted codes. If an unlisted code is used, then supporting documentation must accompany the claim. • Do not indicate rates.
45	Service Date	Enter the date the indicated service was provided.
46	Units of Service	Enter the units of service rendered per procedure.
47	Total Charges	Enter the charge amount for each reported line item.
48	Non-Covered Charges	Enter any non-covered charges for the primary payer pertaining to the revenue code.
49	Untitled	Not applicable.
50 A-C	Payer Name	• List all other health insurance carriers on file. • If applicable, attach an EOB from other carriers.
51	Health Plan ID	List the provider number assigned by the health insurer carrier.
52	Release of Information (REL INFO)	Not applicable.
53	Assignment of Benefits (ASG BEN)	Not applicable.
54	Prior Payments (payer and patient)	• Report all prior payment for the claim. • Attach EOB from another carrier, if applicable.
55	Est. Amount Due	Not applicable.
56	NPI	Enter valid NPI number of the servicing provider.
57 A-C	Other Provider (PRV) ID	Not applicable.
58 A-C	Insured's Name	Enter the name of the individual carrying the insurance.
59 A-C	Patient's Relationship to the Insured (P REL)	Enter the code indicating the relationship of the patient to the identified insured/subscriber.
60 A-C	Insured's Unique ID	Enter the patient's Tufts Health Plan Senior Care Options identification number, including the suffix, as shown on the patient's Tufts Health Plan Senior Care Options member identification card.
61 A-C	Group Name	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance Group Number	Enter the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.
63 A-C	Treatment Authorization Code	Enter the Tufts Health Plan Senior Care Options authorization number
64	Document Control Number	Not applicable.
65	Employer Name	Enter the name of the employer for the individual identified in Box #58, if applicable.
66	DX Version Qualifier	Not applicable.

Box	Field Name	Instructions
67 a-q	Principal Diagnosis Code	• Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for causing this admission/visit. The code must be to the appropriate digit specification, if applicable. • If the diagnosis is accident-related, then an occurrence code and accident date are required. • The POA indicator is the 8th digit of the Field Locator and the 8th digit of each of the Secondary Diagnosis fields, a-q. Report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the 8th digit. • Leave this field blank if the diagnosis is exempt from POA reporting.
68	Other Diagnosis Codes	• Enter the ICD-CM-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently. • If applicable, the code must be to the appropriate digit specification.
69	Admit DX	Enter the ICD-CM-CM diagnosis code provided at the time of admission and as stated by the physician.
70	Patient Reason DX	Optional.
71	PPS (Prospective Payment System) Code	Optional.
72	ECI (External Cause of Injury) Code	Enter the ICD-CM-CM code for the external cause of an injury, poisoning, or adverse effect.
73	Untitled	Not applicable.
74 a-e	Principal Procedure Code (code and date)	• Enter the most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for the service billed. • Also enter the date the procedure was performed. The date must be entered as month and day (MMDD).
75	Untitled	Not applicable.
76	Attending Physician	Enter the ordering physician's NPI, physician's last name, first name and middle initial.
77	Operating	Enter the name and NPI number of the physician who performed the principal procedure, if applicable.
78-79	Other Provider Types	Optional.
80	Remarks	Not applicable.
81 a-d	ICC	Optional.

Figure 2: CMS-1500 (02/12) Claim Form Specifications

Box	Field Name	Instructions
1	Type of Insurance Coverage	• Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional. • If the *Other* box is checked, complete Box #9.
1a	Insured's ID Number	• Enter the patient's current identification number exactly as it appears on the member's Tufts Health Plan Senior Care Options ID card, including the alpha prefix and number suffix. • Inaccurate or incomplete ID numbers will delay processing the claim and can result in a denial.
2	Patient's Name	Enter patient's last name, first name and middle initial, if any, as shown on the patient's Tufts Health Plan Senior Care Options ID card.
3	Patient's Birth Date and Sex	Enter patient's date of birth and sex.
4	Insured's Name	• If the insured and the patient are the same person, enter **SAME**. • If the insured and the patient are not the same person, enter the name of the insured (last name, first name and middle initial).
5	Patient's Address	Enter the patient's permanent mailing address and telephone number: • On the first line, enter the street address. • On the second line, enter the city and state. • On the third line, enter the zip code and telephone number.
6	Patient Relationship to Insured	Check the appropriate box for the patient's relationship to the insured (self, spouse, child, other).
7	Insured's Address	• If the insured's address is the same as patient's address, enter **SAME**. • If the insured's address is different than the patient's address, enter insured's permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.
8	Reserved for NUCC use	No entry required
9	Other Insured's Name	• If the insured is the same as the person in Box #4, enter **SAME**. • If the insured is not the same as the person in Box #4, enter name of the other insured (last name, first name and middle initial).
9a	Other Insured's Policy or Group Number	If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Reserved for NUCC use	No entry required
9c	Reserved for NUCC use	No entry required
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan name or program name and attach the other insurer's EOB to the claim.
10a-c	Is Patient's Condition Related To:	• For each category (Employment, Auto Accident, Other Accident), check either **YES** or **NO**. • When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection benefits have been exhausted. • Enter the state postal code where the auto accident occurred.
10d	Claim Codes	Enter up to 4 claim condition codes
11	Insured's Policy Group or FECA Number	If the insured has other insurance, indicate the insured's policy or group number.
11a	Insured's Date of Birth and Sex	Enter the insured's date of birth and sex if different from the information in Box #3.

Box	Field Name	Instructions
11b	Other claim ID	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter claim number from other insured's plan to the right of the dotted line
11c	Insurance Plan Name or Program Name	• Enter the insurance plan or program name, if applicable. • This field is used to determine if supplemental or other insurance is involved. If the supplemental or other insurer is a Blue Cross Blue Shield plan, enter the name of the state or geographic area; e.g., Blue Shield of (name of state).
11d	Is There Another Health Benefit Plan?	Check either **YES** or **NO** to indicate if there is another primary health benefit plan. For example, a patient may be covered under insurance held by a spouse, parent, or other person.
12	Patient's or Authorized Person's Signature	• If the signature is not on file, the patient or authorized representative must sign and date this box. • If the signature is on file, enter **Signature on File**. • If an authorized representative signs, indicate this person's relationship to the patient.
13	Insured's or Authorized Person's Signature	• If the signature is not on file, the insured or authorized representative must sign this block to authorize payment of benefits to the participating provider or supplier. • If the signature is on file, enter **Signature on File**.
14	Date of current illness, injury or pregnancy (LMP)	Enter date of current illness, injury or pregnancy in the designated MM/DD/YY space. Enter the qualifier found in the 837 electronic claim to the right of the QUAL dotted line
15	Other date	Enter the qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL. Enter the date in the designated MM/DD/YY space.
16	Dates Patient Unable to Work In Current Occupation	If the patient is unable to work in current occupation, enter the dates. An entry in this box could indicate employment-related insurance coverage.
17	Name of referring provider or other source	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter the name of the referring and/or ordering physician or other source if the patient : Was referred to the performing physician for consultation or treatment Was referred to an entity, such as clinical laboratory, for a service Obtained a physician's order for an item or service from an entity, such as a DME supplier
17a-b	ID Number of Referring Physician	• Enter the NPI-assigned physician identification number of the referring or ordering physician. • Referring physician information is required if another physician referred the patient to the performing physician for consultation or treatment. • Ordering physician information is required if a physician ordered the diagnostic services, test, or equipment.
18	Hospitalization Dates Related to Current Services	Enter the admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information (Designated by NUCC)	Enter additional claim information
20	Outside Lab	Check **YES** or **NO** to indicate if laboratory work was performed outside the physician's office.

Box	Field Name	Instructions
21	Diagnoses	Enter the diagnosis/condition of the patient indicated by ICD-CM code number. Enter up to 12 codes in priority order (primary, secondary condition). Codes are arrayed across the box.
22	Resubmission Code	This item identifies a resubmission code
23	Prior Authorization Number	If applicable, enter Tufts Health Plan Senior Care Options' inpatient notification number.
24a	Date(s) of Service	• Enter the dates for each procedure in MMDDYY format, omitting any punctuation. • Itemize each date of service. • Do not use a date range.
24b	Place of Service	Enter the appropriate place of service code.
24c	EMG	Check this item if the service was rendered in a hospital or emergency room.
24d	Procedures, Services, or Supplies	Enter valid CPT/HCPCS procedure codes and any modifiers.
24e	Diagnosis pointer	Enter the diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. Enter a maximum of four letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	$ Charges	Enter the charge for each listed service.
24g	Days or Units	Enter the days or units of service rendered for the procedures reported in Box # 24d.
24h	EPSDT Family Plan	Check this box if early and periodic screening, diagnosis and treatment, or family planning services were used.
24i	ID Qual	Check this box if the service was rendered in a hospital emergency room. **Note:** If this box is checked, the place of service code in Field # 24b should match.
24j	Rendering Provider ID #	If the rendering provider is not the billing provider, enter the rendering provider's NPI number.
25	Federal Tax ID Number	Enter the physician/supplier's federal tax ID, employer ID number, or Social Security number.
26	Patient's Account Number	• Enter the patient's account number assigned by the physician's/supplier's accounting system. • This is an optional field to enhance patient identification by the physician or supplier.
27	Accept Assignment?	• Check **YES** or **NO** to indicate whether the physician accepts assignment for the claim. • By accepting assignment, the physician agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter.
28	Total Charge	Enter the total charges for the services (i.e., the total of all charges in Box #24f).
29	Amount Paid	• Enter the total amount paid by any other carrier/entity for the submitted charges in Box #28. • Attach supporting documentation of any payments (such as EOB, *EOP* and a copy of a cancelled check).
30	Reserved for NUCC use	No entry required
31	Signature of Physician or Supplier Including Degrees or Credentials	• If the signature is not on file, have the physician/supplier or authorized representative sign and date this block. • If the signature is on file, enter **Signature on File**.

Box	Field Name	Instructions
32, 32a-b	Service Facility Location Information	If other than home or office, enter the name and address of the facility where services were rendered to the patient: • Enter the NPI number for the facility • Enter other ID number, if applicable
33, 33a	Billing Provider Info & Phone #	• Enter the name and payment address of the entity receiving payment. This must match the Tax ID and name on file with the Internal Revenue Service. • Enter the NPI number for the entity receiving payment.

Last reviewed 02/2016. Chapter revision dates may not be reflective of actual policy changes.
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