

# National Uniform Claim Committee

## 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version

### Disclaimer and Notices

© 2005 American Medical Association

This document is published in cooperation with the National Uniform Claim Committee (NUCC) by the American Medical Association (AMA). Permission is granted to any individual to copy and distribute this material as long as the copyright statement is included, the contents are not changed, and the copies are not sold or licensed. Applicable FARS/DFARS restrictions apply.

The NUCC has developed this general instructions document for completing the 1500 Health Insurance Claim Form. This document is intended to be a guide for completing the 1500 Claim Form and not definitive instructions for this purpose. Any user of this document should refer to the most current federal, state, or other payer instructions for specific requirements applicable to using the 1500 Claim Form.

The NUCC Reference Instruction Manual must remain intact. Any payer-specific or other organization-specific instructions for completion of the 1500 Claim Form need to be maintained in a separate document.

The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by the AMA or the NUCC. You should consult with an appropriate professional if you need legal or other advice. The listing of an organization or the provision of a link to a web site does not imply any endorsement by the AMA or the NUCC or by any of its members for the products, services, and/or Internet sites listed.

This document is provided “as is” without representation or warranty of any kind either express or implied. The AMA and the NUCC and its members shall not be responsible for any use or non use of this document.

## **1500 CLAIM FORM INSTRUCTIONS: BACKGROUND INFORMATION**

The 1500 Health Insurance Claim Form answers the needs of many health payers. It is the basic paper claim form prescribed by many health plans for claims submitted by physicians and suppliers, and in some cases, for ambulance services.

In the 1960s there were a number of different claim forms and coding systems required by third-party payers to communicate information regarding procedures and services to agencies concerned with insurance claims. However, there was no standardized form for physicians and other health care providers to report health care services. Therefore, the American Medical Association (AMA) embraced an assignment in the 1980s to work with the Centers for Medicare & Medicaid Services (CMS; formerly known as HCFA), and many other payer organizations through a group called the Uniform Claim Form Task Force to standardize and promote the use of a universal health claim form. As a result of this joint effort, the 1500 Claim Form is accepted nationwide by most insurance entities as the standard claim form/attending physician statement for submission of medical claims.

With the transition to an increase in electronic claims submission and the Health Insurance Portability and Accountability Act (HIPAA) regulations, the Uniform Claim Form Task Force was replaced by the National Uniform Claim Committee (NUCC) in the mid 1990s. The NUCC's goal was to develop the NUCC Data Set (NUCC-DS), a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The NUCC continues to be responsible for the maintenance of the 1500 Claim Form. After considerable research to determine if the claim form needed updating in the late 1990s, the NUCC determined that the cost to implement any changes to the form at that time would exceed any projected gains.

Although many providers now submit electronic claims, many of their software/hardware systems depend on the existing 1500 Claim Form in its current image. Minor changes have been made to the form in order to accommodate the National Provider Identifier (NPI) as well as current identifiers for a transition period until the NPI is implemented.

The NUCC approved the initial 1500 Claim Form Instruction Manual in November, 2005 and subsequent updated versions. The instructions are not specific to any applicable public or private payer. The NUCC will continue to research the type of data that are typically reported in the "reserved for local use" fields as well as the required data elements in the other fields that may apply to public and private payers. Therefore, the instructions will continue to evolve. The ultimate goal of the NUCC is to develop standardized national instructions. The end result may require additional changes to the 1500 Claim Form in the future.

## 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"/><br>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID) |  |  |  |  |  |  |  |  |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  |  |  |  |  |  |  |  |  |  | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)   |  |  |  |  |  |  |  |  |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 7. INSURED'S ADDRESS (No., Street)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| CITY   |  |  |  |  |  |  |  |  |  | STATE   |  |  |  |  |  |  |  |  |  | CITY  |  |  |  |  |  |  |  |  |  | STATE                                  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| ZIP CODE   |  |  |  |  |  |  |  |  |  | TELEPHONE (Include Area Code) ( )   |  |  |  |  |  |  |  |  |  | ZIP CODE  |  |  |  |  |  |  |  |  |  | TELEPHONE (Include Area Code) ( )      |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  |  |  |  |  |  |  |  |  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/><br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |  |  |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/><br>b. EMPLOYER'S NAME OR SCHOOL NAME<br>c. INSURANCE PLAN NAME OR PROGRAM NAME<br>d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER  |  |  |  |  |  |  |  |  |  | b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | c. EMPLOYER'S NAME OR SCHOOL NAME   |  |  |  |  |  |  |  |  |  | d. 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.<br>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.<br>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. NPI  |  |  |  |  |  |  |  |  |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 19. RESERVED FOR LOCAL USE   |  |  |  |  |  |  |  |  |  | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES  |  |  |  |  |  |  |  |  |  | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)<br>1. _____ 3. _____<br>2. _____ 4. _____   |  |  |  |  |  |  |  |  |  | 23. PRIOR AUTHORIZATION NUMBER  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 1  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | NPI   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 2  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | NPI   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 3  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | NPI   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 4  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | NPI   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 5  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | NPI   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 6  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | NPI   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 26. PATIENT'S ACCOUNT NO.   |  |  |  |  |  |  |  |  |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |  |  | 28. TOTAL CHARGE \$                    |  |  |  |  |  |  |  |  |  | 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.)   |  |  |  |  |  |  |  |  |  | 32. SERVICE FACILITY LOCATION INFORMATION<br>a. NPI b.  |  |  |  |  |  |  |  |  |  | 33. BILLING PROVIDER INFO & PH # ( )  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |
| SIGNED _____ DATE _____  |  |  |  |  |  |  |  |  |  | a. NPI b.   |  |  |  |  |  |  |  |  |  | a. NPI b.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |                    |  |  |  |  |  |  |  |  |  |

## OVERALL INSTRUCTIONS

Each Item Number includes the title, instructions, description, field specifications, and example. The examples provided in the instructions are demonstrating how to enter the data in the field. They are not providing instruction on how to bill for certain services.

### **Punctuation**

The use of punctuation is noted in the instructions section of each Item Number.

**Please note:** Form images throughout this manual may not be to scale.

## CARRIER BLOCK

1500  
**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05  
 PICA

CARRIER -

1st Line – Name  
2nd Line – First line of address  
3rd Line – Second line of address  
4th Line – City State (2 digits) and Zip Code

| Line | Descriptor               | Type | Bytes | Columns |
|------|--------------------------|------|-------|---------|
| 4    | Payer Name               | A/N  | 41    | 38-78   |
| 5    | Payer Address 1          | A/N  | 41    | 38-78   |
| 6    | Payer Address 2          | A/N  | 41    | 38-78   |
| 7    | Payer City State and Zip | A/N  | 41    | 38-78   |

1st Line – Name  
2nd Line – Line of address  
3rd Line – Leave blank  
4th Line – City State (2 digits) and Zip Code

| Line | Descriptor               | Type | Bytes | Columns |
|------|--------------------------|------|-------|---------|
| 4    | Payer Name               | A/N  | 41    | 38-78   |
| 5    | Payer Address            | A/N  | 41    | 38-78   |
| 6    | Leave blank              |      |       |         |
| 7    | Payer City State and Zip | A/N  | 41    | 38-78   |

When printing page numbers on multiple page claims (general done by clearinghouses when converting the 837P 4010A1 to the 1500 Claim Form), print the page numbers in the Carrier Block on Line 8 beginning at column 32. Page numbers are to be printed as:

Page XX of YY

**Description:** The payer is the carrier, health plan, third-party administrator, or other payer who will handle the claim. This information directs the claim to the appropriate payer.

**Example:**

Four line address:

|   |                       |  |
|---|-----------------------|--|
| 1500  | ABC Insurance Company | CARRIER  |
|   | Suite 600             |  |
|   | 567 Insurance Lane    |  |
|   | Big City, IL 60605    |  |
| <b>HEALTH INSURANCE CLAIM FORM</b>                                |                       |  |
| <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small> |                       |  |
| <input type="checkbox"/> <input type="checkbox"/> PICA            | Page 01 of 02         | PICA <input type="checkbox"/> <input type="checkbox"/> |

Three line address:

|   |                       |  |
|---|-----------------------|--|
| 1500  | ABC Insurance Company | CARRIER  |
|   | 567 Insurance Lane    |  |
|   | Big City, IL 60605    |  |
| <b>HEALTH INSURANCE CLAIM FORM</b>                                |                       |  |
| <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small> |                       |  |
| <input type="checkbox"/> <input type="checkbox"/> PICA            | Page 01 of 02         | PICA <input type="checkbox"/> <input type="checkbox"/> |

## ITEMS 1–13: PATIENT AND INSURED INFORMATION

### Item Number 1

|  |   |   |   |   |   |   |
|--|---|---|---|---|---|---|
| 1. MEDICARE<br><input type="checkbox"/> (Medicare #) | MEDICAID<br><input type="checkbox"/> (Medicaid #) | TRICARE<br>CHAMPUS<br>(Sponsor's SSN)<br><input type="checkbox"/> | CHAMPVA<br>(Member ID#)<br><input type="checkbox"/> | GROUP<br>HEALTH PLAN<br>(SSN or ID)<br><input type="checkbox"/> | FECA<br>BLK LUNG<br>(SSN)<br><input type="checkbox"/> | OTHER<br>(ID)<br><input type="checkbox"/> |
|--|---|---|---|---|---|---|

**Title:** Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other

**Instructions:** Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.

**Description:** Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, or Other means the insurance type to whom the claim is being submitted. Other indicates health insurance including HMOs, commercial insurance, automobile accident, liability, or workers' compensation. This information directs the claim to the correct program and may establish primary liability.

**Field Specifications:** This field allows for entry of 1 character in any box within the field.

#### Example:

|  |   |   |   |  |   |   |
|--|---|---|---|--|---|---|
| 1. MEDICARE<br><input type="checkbox"/> (Medicare #) | MEDICAID<br><input type="checkbox"/> (Medicaid #) | TRICARE<br>CHAMPUS<br>(Sponsor's SSN)<br><input type="checkbox"/> | CHAMPVA<br>(Member ID#)<br><input type="checkbox"/> | GROUP<br>HEALTH PLAN<br>(SSN or ID)<br><input checked="" type="checkbox"/> | FECA<br>BLK LUNG<br>(SSN)<br><input type="checkbox"/> | OTHER<br>(ID)<br><input type="checkbox"/> |
|--|---|---|---|--|---|---|

### Item Number 1a

|                                   |                         |
|-----------------------------------|-------------------------|
| 1a. INSURED'S I.D. NUMBER<br><br> | (For Program in Item 1) |
|-----------------------------------|-------------------------|

**Title:** Insured's ID Number

**Instructions:** Enter insured's ID number as shown on insured's ID card for the payer to whom the claim is being submitted.

**Description:** The insured's ID number is the identification number of the person who holds the policy. This information identifies the patient to the payer.

**Field Specification:** This field allows for entry of 29 characters.

#### Example:

|  |                         |
|--|-------------------------|
| 1a. INSURED'S I.D. NUMBER<br>X0123456789 | (For Program in Item 1) |
|--|-------------------------|

## Item Number 2

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

**Title:** Patient's Name

**Instructions:** Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

**Description:** The patient's name is the name of the person who received the treatment or supplies.

**Field Specification:** This field allows for the entry of 28 characters.

**Example:**

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

Doe Jr, John, J

## Item Number 3

3. PATIENT'S BIRTH DATE SEX  
MM DD YY M F

**Title:** Patient's Birth Date, Sex

**Instructions:** Enter the patient's 8-digit birth date (MM | DD | CCYY). Enter an X in the correct box to indicate sex of the patient. Only one box can be marked. If gender is unknown, leave blank.

**Description:** The patient's birth date and sex (gender) is information that will identify the patient and it distinguishes persons with similar names.

**Field Specification:** This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, 4 characters under YY, and 1 character in either box.

**Example:**

3. PATIENT'S BIRTH DATE SEX  
MM DD YY M F  
01 01 1987 M X F



## Item Number 4

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

**Title:** Insured's Name

**Instructions:** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

**Description:** The insured's name identifies the person who holds the policy, which would be the employee for employer-provided health insurance.

**Field Specification:** This field allows for the entry of 29 characters.

**Example:**

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

Doe, John, J

## Item Number 5

|                                    |  |       |
|------------------------------------|--|-------|
| 5. PATIENT'S ADDRESS (No., Street) |  |       |
| CITY                               |  | STATE |
| ZIP CODE                           | TELEPHONE (Include Area Code)<br>(     ) |       |

**Title:** Patient's Address (multiple fields)

**Instructions:** Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the zip code and phone number. Patient's Telephone does not exist in the electronic 837 Professional 4010A1.

Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a 9 digit zip code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.

**Description:** The patient's address refers to the patient's permanent residence. A temporary address or school address should not be used.

**Field Specification:** This field allows for the entry of the following: 28 characters for street address, 24 characters for city, 3 characters for state, 12 characters for zip code, 3 characters for area code, and 10 characters for phone number.

### Example:

|                                    |                               |       |
|------------------------------------|-------------------------------|-------|
| 5. PATIENT'S ADDRESS (No., Street) |                               |       |
| 123 Main Street                    |                               |       |
| CITY                               |                               | STATE |
| Anytown                            |                               | IL    |
| ZIP CODE                           | TELEPHONE (Include Area Code) |       |
| 60610                              | (312) 5551212                 |       |

### Item Number 6

|                                    |                          |        |                          |       |                          |       |                          |
|------------------------------------|--------------------------|--------|--------------------------|-------|--------------------------|-------|--------------------------|
| 6. PATIENT RELATIONSHIP TO INSURED |                          |        |                          |       |                          |       |                          |
| Self                               | <input type="checkbox"/> | Spouse | <input type="checkbox"/> | Child | <input type="checkbox"/> | Other | <input type="checkbox"/> |

**Title:** Patient Relationship to Insured

**Instructions:** Enter an X in the correct box to indicate the patient's relationship to insured when Item Number 4 is completed. Only one box can be marked.

**Description:** The patient relationship to insured refers to how the patient is related to the insured. Self would indicate that the insured is the patient. Spouse would indicate that the patient is the husband or wife or qualified partner as defined by the insured's plan. Child would indicate that the patient is the minor dependent as defined by the insured's plan. Other would indicate that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent as defined by the insured's plan.

**Field Specification:** This field allows for entry of 1 character in any box within the field.

**Example:**

|                                    |                          |        |                          |       |                                     |       |                          |
|------------------------------------|--------------------------|--------|--------------------------|-------|-------------------------------------|-------|--------------------------|
| 6. PATIENT RELATIONSHIP TO INSURED |                          |        |                          |       |                                     |       |                          |
| Self                               | <input type="checkbox"/> | Spouse | <input type="checkbox"/> | Child | <input checked="" type="checkbox"/> | Other | <input type="checkbox"/> |

### Item Number 7

|                                    |   |       |
|------------------------------------|---|-------|
| 7. INSURED'S ADDRESS (No., Street) |   |       |
| CITY                               |   | STATE |
| ZIP CODE                           | TELEPHONE (Include Area Code)<br>(      ) |       |

**Title:** Insured's Address (multiple fields)

**Instructions:** Enter the insured's address and telephone number. If Item Number 4 is completed then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the zip code and phone number. Patient's Telephone does not exist in the electronic 837 Professional 4010A1.

Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a 9 digit zip code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.

**Description:** The insured's address refers to the insured's permanent residence, which may be different from the patient's address in Item Number 5.

**Field Specification:** This field allows for the entry of the following: 29 characters for street address, 23 characters for city, 4 characters for state, 12 characters for zip code, 3 characters for area code, and 10 characters for phone number.

**Example:**

|                                    |                               |       |
|------------------------------------|-------------------------------|-------|
| 7. INSURED'S ADDRESS (No., Street) |                               |       |
| 123 Main Street                    |                               |       |
| CITY                               |                               | STATE |
| Anytown                            |                               | IL    |
| ZIP CODE                           | TELEPHONE (Include Area Code) |       |
| 60610                              | (312)5551212                  |       |

## Item Number 8

|                   |                          |                   |                          |                   |                          |
|-------------------|--------------------------|-------------------|--------------------------|-------------------|--------------------------|
| 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"/> |

**Title:** Patient Status

**Instructions:** Patient Status does not exist in the electronic 837 Professional 4010A1.

Enter an X in the box for the patient's marital status, and for the patient's employment or student status. Only one box on each line can be marked.

**Description:** The patient status indicates the patient's marital and employment status. Employed would indicate that the patient has a job. Full-time student would indicate that the patient is registered as a full-time student as defined by the post-secondary school or university. Part-time student would indicate that the patient is registered as a part-time student as defined by the post-secondary school or university. This information is important for determination of liability and coordination of benefits (COB).

**Field Specification:** This field allows for entry of 1 character in any box within the field.

### Example:

|                   |                                     |                   |                          |                   |                          |
|-------------------|-------------------------------------|-------------------|--------------------------|-------------------|--------------------------|
| 8. PATIENT STATUS |                                     |                   |                          |                   |                          |
| Single            | <input checked="" type="checkbox"/> | Married           | <input type="checkbox"/> | Other             | <input type="checkbox"/> |
| Employed          | <input checked="" type="checkbox"/> | Full-Time Student | <input type="checkbox"/> | Part-Time Student | <input type="checkbox"/> |

## Item Number 9

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

**Title:** Other Insured's Name

**Instructions:** If Item Number 11d is marked, complete fields 9 and 9a-d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

**Description:** The other insured's name indicates that there is a holder of another policy that may cover the patient.

**Field Specification:** This field allows for the entry of 28 characters.

**Example:**

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

Doe, Mary, A

---

## Item Number 9a

a. OTHER INSURED'S POLICY OR GROUP NUMBER

**Title:** Other Insured's Policy or Group Number

**Instructions:** Enter the policy or group number of the other insured.

Do not use a hyphen or space as a separator within the policy or group number.

**Description:** The other insured's policy or group number identifies the policy or group number for coverage of the insured as indicated in Item Number 9.

**Field Specification:** This field allows for the entry of 28 characters.

**Example:**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

X9876543210

### Item Number 9b

|                                  |    |    |                            |                            |
|----------------------------------|----|----|----------------------------|----------------------------|
| b. OTHER INSURED'S DATE OF BIRTH |    |    | SEX                        |                            |
| MM                               | DD | YY | M <input type="checkbox"/> | F <input type="checkbox"/> |

**Title:** Other Insured's Date of Birth, Sex

**Instructions:** Enter the 8-digit date of birth (MM | DD | CCYY) of the other insured and an X to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.

**Description:** The other insured's date of birth and sex (gender) identifies the birth date and gender of the insured as indicated in Item Number 9.

**Field Specification:** This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, 4 characters under YY, and 1 character in either box.

**Example:**

|                                  |    |      |                            |                                       |
|----------------------------------|----|------|----------------------------|---------------------------------------|
| b. OTHER INSURED'S DATE OF BIRTH |    |      | SEX                        |                                       |
| MM                               | DD | YY   | M <input type="checkbox"/> | F <input checked="" type="checkbox"/> |
| 01                               | 01 | 1960 |                            |                                       |

---

### Item Number 9c

|                                   |
|-----------------------------------|
| c. EMPLOYER'S NAME OR SCHOOL NAME |
|-----------------------------------|

**Title:** Employer's Name or School Name

**Instructions:** Employer's Name and School Name do not exist in the electronic 837 Professional 4010A1. Enter the name of the other insured's employer or school.

**Description:** The employer's name or school name identifies the name of the employer or school attended by the other insured as indicated in Item Number 9.

**Field Specification:** This field allows for the entry of 28 characters.

**Example:**

|                                   |
|-----------------------------------|
| c. EMPLOYER'S NAME OR SCHOOL NAME |
| Community Hospital                |

**Item Number 9d**

d. INSURANCE PLAN NAME OR PROGRAM NAME

**Title:** Insurance Plan Name or Program Name

**Instructions:** Enter the other insured's insurance plan or program name.

**Description:** The insurance plan name or program name identifies the name of the plan or program of the other insured as indicated in Item Number 9.

**Field Specification:** This field allows for the entry of 28 characters.

**Example:**

d. INSURANCE PLAN NAME OR PROGRAM NAME

XYZ Insurance Company



### Item Numbers 10a–10c

|  |                              |   |
|--|------------------------------|---|
| 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                     |

**Title:** Is Patient's Condition Related To:

**Instructions:** When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.

The state postal code must be shown if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.

**Description:** This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. Employment (current or previous) would indicate that the condition is related to the patient's job or workplace. Auto accident would indicate that the condition is the result of an automobile accident. Other accident would indicate that the condition is the result of any other type of accident.

**Field Specification:** This field allows for the entry of the following: 1 character in either box per each line and 2 characters in the Place/State field

**Example:**

|  |  |  |
|--|--|--|
| 10. IS PATIENT'S CONDITION RELATED TO: |  |  |
| a. EMPLOYMENT? (Current or Previous)   |  |  |
| <input type="checkbox"/> YES           | <input checked="" type="checkbox"/> NO |  |
| b. AUTO ACCIDENT?                      | <input type="checkbox"/> YES           | <input checked="" type="checkbox"/> NO PLACE (State) _____ |
| c. OTHER ACCIDENT?                     | <input type="checkbox"/> YES           | <input checked="" type="checkbox"/> NO                     |

### Item Number 10d

10d. RESERVED FOR LOCAL USE

**Title:** Reserved for Local Use

**Instructions:** Please refer to the most current instructions from the applicable public or private payer regarding the use of this field.

When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at [www.nucc.org](http://www.nucc.org) under Code Sets.

**Field Specification:** This field allows for the entry of 19 characters.

**Example:** None

---

### Item Number 11

11. INSURED'S POLICY GROUP OR FECA NUMBER

**Title:** Insured's Policy, Group, or FECA Number

**Instructions:** Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed.

Do not use a hyphen or space as a separator within the policy or group number.

**Description:** The insured's policy, group, or FECA number refers to the alphanumeric identifier for the health, auto, or other insurance plan coverage. For worker's compensation claims the worker's compensation carrier's alphanumeric identifier would be used. The FECA number is the 9-digit alphanumeric identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101.

**Field Specification:** This field allows for the entry of 29 characters.

**Example:**

11. INSURED'S POLICY GROUP OR FECA NUMBER

A1234

### Item Number 11a

|                            |    |    |                            |                            |
|----------------------------|----|----|----------------------------|----------------------------|
| a. INSURED'S DATE OF BIRTH |    |    | SEX                        |                            |
| MM                         | DD | YY | M <input type="checkbox"/> | F <input type="checkbox"/> |

**Title:** Insured's Date of Birth, Sex

**Instructions:** Enter the 8-digit date of birth (MM | DD | CCYY) of the insured and an X to indicate the sex of the insured. Only one box can be marked. If gender is unknown, leave blank.

**Description:** The insured's date of birth and sex (gender) refers to the birth date and gender of the insured as indicated in Item Number 1a.

**Field Specification:** This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, 4 characters under YY, and 1 character in either box.

**Example:**

|                            |    |      |                                       |                            |
|----------------------------|----|------|---------------------------------------|----------------------------|
| a. INSURED'S DATE OF BIRTH |    |      | SEX                                   |                            |
| MM                         | DD | YY   | M <input checked="" type="checkbox"/> | F <input type="checkbox"/> |
| 01                         | 01 | 1958 |                                       |                            |

---

### Item Number 11b

|                                   |
|-----------------------------------|
| b. EMPLOYER'S NAME OR SCHOOL NAME |
|-----------------------------------|

**Title:** Insured's Employer's Name or School Name

**Instructions:** Employer's Name and School Name do not exist in the electronic 837 Professional 4010A1. Enter the name of the insured's employer or school.

**Description:** The insured's employer's name or school name refers to the name of the employer or school attended by the insured as indicated in Item Number 1a.

**Field Specification:** This field allows for the entry of 29 characters.

**Example:**

|                                   |
|-----------------------------------|
| b. EMPLOYER'S NAME OR SCHOOL NAME |
| Local Company                     |

**Item Number 11c**

c. INSURANCE PLAN NAME OR PROGRAM NAME

**Title:** Insurance Plan Name or Program Name

**Instructions:** Enter the insurance plan or program name of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.

**Description:** The insurance plan name or program name refers to the name of the plan or program of the insured as indicated in Item Number 1a.

**Field Specification:** This field allows for the entry of 29 characters.

**Example:**

c. INSURANCE PLAN NAME OR PROGRAM NAME

ABC Insurance Company

---

**Item Number 11d**

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

☐

YES

☐

NO

*If yes, return to and complete item 9 a-d.*

**Title:** Is there another Health Benefit Plan?

**Instructions:** When appropriate, enter an X in the correct box. If marked "YES", complete 9 and 9a–d. Only one box can be marked.

**Description:** "Is there another health benefit plan" indicates that the patient has insurance coverage other than the plan indicated in Item Number 1.

**Field Specification:** This field allows for the entry of 1 character in either box.

**Example:**

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

☒

YES

☐

NO

*If yes, return to and complete item 9 a-d.*

## Item Number 12

|  |            |
|--|------------|
| <b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>  |            |
| 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 _____ |

**Title:** Patient's or Authorized Person's Signature

**Instructions:** Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6 digit format (MMDDYY) or 8-digit format (MMDDCCYY). If there is no signature on file, leave blank or enter "No Signature on File."

**Description:** The patient's or authorized person's signature indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

**Field Specification:** Use the space available to enter signature/information and date.

**Example:**

|  |            |
|--|------------|
| <b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>  |            |
| 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 <u>SOF</u>  | DATE _____ |

---

## Item Number 13

|   |
|---|
| 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 _____  |

**Title:** Insured's or Authorized Person's Signature

**Instructions:** Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."

**Description:** The insured's or authorized person's signature indicates that there is a signature on file authorizing payment of medical benefits.

**Field Specification:** Use the space available to enter signature/information.

**Example:**

|   |
|---|
| 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 <u>SOF</u>   |

## ITEMS 14–33: PHYSICIAN OR SUPPLIER INFORMATION

### Item Number 14

|                      |                            |
|----------------------|----------------------------|
| 14. DATE OF CURRENT: | ILLNESS (First symptom) OR |
| MM DD YY             | INJURY (Accident) OR       |
|                      | PREGNANCY(LMP)             |

**Title:** Date of Current Illness, Injury, Pregnancy

**Instructions:** Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

**Description:** The date of current illness, injury, pregnancy refers to the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.

**Field Specification:** This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, and 4 characters under YY.

**Example:**

|                      |                            |
|----------------------|----------------------------|
| 14. DATE OF CURRENT: | ILLNESS (First symptom) OR |
| MM DD YY             | INJURY (Accident) OR       |
| 09 30 2005           | PREGNANCY(LMP)             |

---

### Item Number 15

|   |
|---|
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. |
| GIVE FIRST DATE MM DD YY                        |

**Title:** If Patient Has Had Same or Similar Illness

**Instructions:** Enter the first date the patient had the same or a similar illness. Enter the date in the 6-digit format (MM | DD | YY) or 8-digit format (MM | DD | CCYY). Previous pregnancies are not a similar illness. Leave blank if unknown.

**Description:** A patient having had same or similar illness would indicate that the patient had a previously related condition.

**Field Specification:** This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, and 4 characters under YY.

**Example:**

|   |
|---|
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. |
| GIVE FIRST DATE MM DD YY                        |
| 09 25 2005                                      |

### Item Number 16

|  |  |    |  |    |  |    |  |    |  |    |  |
|--|--|----|--|----|--|----|--|----|--|----|--|
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION |  |    |  |    |  |    |  |    |  |    |  |
| MM   |  | DD |  | YY |  | MM |  | DD |  | YY |  |
| FROM   |  |    |  |    |  |    |  | TO |  |    |  |

**Title:** Dates Patient Unable to Work in Current Occupation

**Instructions:** If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date must be shown for the "from-to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

**Description:** Dates patient unable to work in current occupation would refer to the time span the patient is or was unable to work.

**Field Specification:** This field allows for the entry of the following in each of the date fields: 2 characters under MM, 2 characters under DD, and 4 characters under YY.

**Example:**

|  |  |    |  |      |  |    |  |    |  |    |  |
|--|--|----|--|------|--|----|--|----|--|----|--|
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION |  |    |  |      |  |    |  |    |  |    |  |
| MM   |  | DD |  | YY   |  | MM |  | DD |  | YY |  |
| FROM   |  |    |  | 09   |  |    |  | 25 |  |    |  |
|  |  |    |  | 2005 |  |    |  | TO |  |    |  |
|  |  |    |  | 10   |  |    |  | 28 |  |    |  |
|  |  |    |  | 2005 |  |    |  |    |  |    |  |

---

### Item Number 17

|  |
|--|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE |
|--|

**Title:** Name of Referring Provider or Other Source

**Instructions:** Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supply(s) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas within the name. A hyphen can be used for hyphenated names.

**Description:** The name is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(s) on the claim.

**Field Specification:** This field allows for the entry of 26 characters.

**Example:**

|  |
|--|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE |
| Jane A Smith MD                                |

**Item Number 17a and 17b (split field)**

|      |     |  |
|------|-----|--|
| 17a. |     |  |
| 17b. | NPI |  |

**Title 17a:** Other ID#

**Instructions 17a:** The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- E1 Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The social security number may not be used for Medicare.)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

**Description:** The non-NPI ID number of the referring, ordering, or supervising provider refers to the payer assigned unique identifier of the professional.

**Field Specification:** This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.

**Title 17b:** NPI #

**Instructions 17b:** Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

**Description:** The NPI number refers to the HIPAA National Provider Identifier number.

**Field Specification:** This field allows for the entry of a 10 digit NPI number.

**Example:**

|      |     |               |
|------|-----|---------------|
| 17a. | 1B  | ABC1234567890 |
| 17b. | NPI | 0123456789    |



## Item Number 18

|   |  |    |  |    |  |    |  |    |  |    |  |
|---|--|----|--|----|--|----|--|----|--|----|--|
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |  |    |  |    |  |    |  |    |  |    |  |
| MM  |  | DD |  | YY |  | MM |  | DD |  | YY |  |
| FROM  |  |    |  | TO |  |    |  |    |  |    |  |

**Title:** Hospitalization Dates Related to Current Services

**Instructions:** Enter the inpatient 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

**Description:** The hospitalization dates related to current services would refer to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

**Field Specification:** This field allows for the entry of the following in each of the date fields: 2 characters under MM, 2 characters under DD, and 4 characters under YY.

**Example:**

|   |  |    |  |                   |  |    |  |    |  |    |  |
|---|--|----|--|-------------------|--|----|--|----|--|----|--|
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |  |    |  |                   |  |    |  |    |  |    |  |
| MM  |  | DD |  | YY                |  | MM |  | DD |  | YY |  |
| FROM 09   25   2005                                   |  |    |  | TO 09   28   2005 |  |    |  |    |  |    |  |

---

## Item Number 19

|                            |
|----------------------------|
| 19. RESERVED FOR LOCAL USE |
|----------------------------|

**Title:** Reserved for local use

**Instructions:** Please refer to the most current instructions from the applicable public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The social security number may not be used for Medicare.)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

**Field Specification:** This field allows for the entry of 83 characters.

**Example:** None

## Item Number 20

|  |            |
|--|------------|
| 20. OUTSIDE LAB?   | \$ CHARGES |
| <input type="checkbox"/> YES <input type="checkbox"/> NO |            |

**Title:** Outside Lab? \$Charges

**Instructions:** Complete this field when billing for purchased services. Enter an X in "YES" if the reported service(s) was performed by an entity other than the billing provider. If "YES", enter the purchased price under charges. A "YES" mark indicates that an entity other than the entity billing for the service performed the purchased services. A "NO" mark indicates that no purchased services are included on the claim. When "YES" is annotated, Item Number 32 must be completed. When billing for multiple purchased services, each service should be submitted on a separate claim form. Only one box can be marked.

When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter the number right justified to the left of the vertical line. Do not use commas or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Use 00 for the cents if the amount is a whole number. Leave the right-hand field blank.

**Description:** Outside lab? \$Charges indicates that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs.


**Field Specification:** This field allows for the entry of the following: 1 character in either box in the Outside Lab area and 8 characters to the left of the vertical line in the \$Charges area.

**Example:**

|   |            |
|---|------------|
| 20. OUTSIDE LAB?  | \$ CHARGES |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 112500     |

|   |            |
|---|------------|
| 20. OUTSIDE LAB?  | \$ CHARGES |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 112575     |

## Item Number 21

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

**Title:** Diagnosis or Nature of Illness or Injury (relate items 1, 2, 3, or 4 to 24E by line)


**Instructions:** Enter the patient's diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Relate lines 1, 2, 3, 4 to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this field.

When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit on top of the period.

**Description:** The diagnosis or nature of illness or injury refers to the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

**Field Specification:** This field allows for the entry 3 characters prior to the period, 1 character above the period, and 4 characters after the period in each of the four line areas.

### Example:

|  |            |   |
|--|------------|---|
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) |            |  |
| 1. I998 . 59   | 3. I18 . 0 |   |
| 2. I780 . 6  | 4. E87 8 8 |   |
|  |            |   |

## Item Number 22

|                                   |                   |
|-----------------------------------|-------------------|
| 22. MEDICAID RESUBMISSION<br>CODE | ORIGINAL REF. NO. |
|-----------------------------------|-------------------|

**Title:** Medicaid Resubmission

**Instructions:** List the original reference number for resubmitted claims. Please refer to the most current instructions from the applicable public or private payer regarding the use of this field (e.g., code).

**Description:** Medicaid resubmission means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

**Field Specification:** This field allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. area.

**Example:**

|                                   |                   |
|-----------------------------------|-------------------|
| 22. MEDICAID RESUBMISSION<br>CODE | ORIGINAL REF. NO. |
| 123                               | ABC1234567890     |

---

## Item Number 23

|                                |
|--------------------------------|
| 23. PRIOR AUTHORIZATION NUMBER |
|--------------------------------|

**Title:** Prior Authorization Number

**Instructions:** Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

Do not enter hyphens or spaces within the number.

**Description:** The prior authorization number refers to the payer assigned number authorizing the service(s).

**Field Specification:** This field allows for the entry of 29 characters.

**Example:**

|                                |
|--------------------------------|
| 23. PRIOR AUTHORIZATION NUMBER |
| 1234567890A                    |

## Section 24

|   | 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |          |  |  | E. DIAGNOSIS<br>POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. EPSDT<br>Family Plan | I. ID. QUAL | J. RENDERING<br>PROVIDER ID. # |
|---|---------------------------|----|----|----|----|----|---------------------|--------|---|----------|--|--|-------------------------|---------------|------------------|-------------------------|-------------|--------------------------------|
|   | MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS   | MODIFIER |  |  |                         |               |                  |                         |             |                                |
| 1 |                           |    |    |    |    |    |                     |        |   |          |  |  |                         |               |                  |                         |             |                                |
| 2 |                           |    |    |    |    |    |                     |        |   |          |  |  |                         |               |                  |                         |             |                                |
| 3 |                           |    |    |    |    |    |                     |        |   |          |  |  |                         |               |                  |                         |             |                                |
| 4 |                           |    |    |    |    |    |                     |        |   |          |  |  |                         |               |                  |                         |             |                                |
| 5 |                           |    |    |    |    |    |                     |        |   |          |  |  |                         |               |                  |                         |             |                                |
| 6 |                           |    |    |    |    |    |                     |        |   |          |  |  |                         |               |                  |                         |             |                                |

**Instructions:** Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. Providers must verify requirements for this supplemental information with the payer.

See page 40 for further instructions and examples of how to enter supplemental information.

**Field Specifications:** The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

## Item Number 24A

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    |  |
|---------------------------|----|----|----|----|----|--|
| From                      |    |    | To |    |    |  |
| MM                        | DD | YY | MM | DD | YY |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |
|                           |    |    |    |    |    |  |

**Title:** Date(s) of Service [lines 1–6]

**Instructions:** Enter date(s) of service, from and to. If one date of service only, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G.

When required by payers to provide additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information. The information may extend to 24G. Further instructions on entering supplemental information with qualifiers, including examples, are on page 40.

**Description:** Date(s) of service indicate the actual month, day, and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.

**Field Specification:** This field allows for the entry of the following in each of the unshaded date fields: 2 characters under MM, 2 characters under DD, and 2 characters under YY.

### Example:

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    |  |
|---------------------------|----|----|----|----|----|--|
| From                      |    |    | To |    |    |  |
| MM                        | DD | YY | MM | DD | YY |  |
| 09                        | 30 | 05 | 09 | 30 | 05 |  |

## Item Number 24B

|                           |
|---------------------------|
| B.<br>PLACE OF<br>SERVICE |
|                           |
|                           |
|                           |
|                           |
|                           |
|                           |
|                           |

**Title:** Place of Service [lines 1–6]

**Instructions:** In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: [www.cms.hhs.gov/PlaceofServiceCodes/Downloads/POSDataBase.pdf](http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/POSDataBase.pdf).

**Description:** The Place of Service Code identifies the location where the service was rendered.

**Field Specification:** This field allows for the entry of 2 characters in the unshaded area.

**Example:**

|                           |
|---------------------------|
| B.<br>PLACE OF<br>SERVICE |
| 11                        |

**Item Number 24C**

|     |
|-----|
| C.  |
| EMG |
|     |
|     |
|     |
|     |
|     |
|     |
|     |

**Title:** EMG [lines 1–6]

This Item Number was originally titled "Type of Service" and "Type of Service" is no longer used so it has been eliminated.

**Instructions:** Check with trading partner to determine if this element (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in the electronic 837 Professional 4010A1 implementation guide.

**Field Specification:** This field allows for the entry of 2 characters in the unshaded area.

**Example:**

|     |
|-----|
| C.  |
| EMG |
| Y   |



## Item Number 24D

| D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |          |  |  |  |  |
|---|----------|--|--|--|--|
| CPT/HCPCS   | MODIFIER |  |  |  |  |
|   |          |  |  |  |  |
|   |          |  |  |  |  |
|   |          |  |  |  |  |
|   |          |  |  |  |  |
|   |          |  |  |  |  |
|   |          |  |  |  |  |

**Title:** Procedures, Services, or Supplies [lines 1–6]

**Instructions:** Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.

**Description:** The procedures, services or supplies refer to a listing of identifying codes for reporting medical services and procedures.

**Field Specification:** This field allows for the entry of the following: 6 characters in the unshaded area of the CPT/HCPCS field and four sets of 2 characters in the Modifier area.

**Example:**

| D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |          |  |  |  |  |
|---|----------|--|--|--|--|
| CPT/HCPCS   | MODIFIER |  |  |  |  |
| 99241   | 25       |  |  |  |  |

## Item Number 24E

| E.<br>DIAGNOSIS<br>POINTER |
|----------------------------|
|                            |
|                            |
|                            |
|                            |
|                            |
|                            |
|                            |

**Title:** Diagnosis Pointer [lines 1–6]

**Instructions:** In 24E, enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. (ICD-9-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.)

Enter numbers left justified in the field. Do not use commas between the numbers.

**Description:** The diagnosis pointer refers to the line number from Item Number 21 that relates to the reason the service(s) was performed.

**Field Specification:** This field allows for the entry of 4 characters in the unshaded area.

**Example:**

| E.<br>DIAGNOSIS<br>POINTER |
|----------------------------|
| 1234                       |

**Item Number 24F**

| F.         |  |
|------------|--|
| \$ CHARGES |  |
|            |  |
|            |  |
|            |  |
|            |  |
|            |  |
|            |  |
|            |  |
|            |  |

**Title:** \$ Charges [lines 1–6]

**Instructions:** Enter the charge for each listed service.

Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**Description:** \$ charges refers to the total billed amount for each service line.

**Field Specification:** This field allows for the entry of 6 characters to the left of the vertical line and 2 characters to the right of the vertical line in the unshaded area.

**Example:**

| F.         |    |
|------------|----|
| \$ CHARGES |    |
| 50         | 00 |

## Item Number 24G

|                           |
|---------------------------|
| G.<br>DAYS<br>OR<br>UNITS |
|                           |
|                           |
|                           |
|                           |
|                           |
|                           |
|                           |

**Title:** Days or Units [lines 1–6]

**Instructions:** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Enter numbers right justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

When required by payers to provide the NDC units in addition to the HCPCS units, enter the applicable NDC units' qualifier and related units in the shaded line following the NDC qualifier and code. ( See additional information and examples on page 40.)

The following qualifiers are to be used when reporting NDC units:

|    |                    |    |            |
|----|--------------------|----|------------|
| F2 | International Unit | ML | Milliliter |
| GR | Gram               | UN | Unit       |

**Description:** Days or units refers to the number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS coding manual(s).

**Field Specification:** This field allows for the entry of 3 characters in the unshaded area.

### Examples:

|                           |
|---------------------------|
| G.<br>DAYS<br>OR<br>UNITS |
|                           |
| 1                         |

|                           |
|---------------------------|
| G.<br>DAYS<br>OR<br>UNITS |
|                           |
| 1.5                       |

## Item Number 24H

|                               |
|-------------------------------|
| H.<br>EPSDT<br>Family<br>Plan |
|                               |
|                               |
|                               |
|                               |
|                               |
|                               |
|                               |
|                               |
|                               |

**Title:** EPSDT/Family Plan [lines 1–6]

**Instructions:** For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:

If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for “YES” or N for “NO” only.

If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field.

The following codes for EPSDT are used in the electronic 837 Professional 4010A1:

- AV Available – Not Used (Patient refused referral.)
- S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)
- ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/ scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)
- NU Not Used (Used when no EPSDT patient referral was given.)

If the service is Family Planning, enter Y (“YES”) or N (“NO”) in the bottom, unshaded area of the field.

**Description:** The EPSDT/Family Plan identifies certain services that may be covered under some state plans.

**Field Specification:** This field allows for the entry of 1 character in the unshaded area and 2 characters in the shaded area.

### Examples:

|                               |
|-------------------------------|
| H.<br>EPSDT<br>Family<br>Plan |
| Y                             |
| Y                             |

|                               |
|-------------------------------|
| H.<br>EPSDT<br>Family<br>Plan |
| S2                            |
| N                             |

## Item Number 24I

|                    |
|--------------------|
| I.<br>ID.<br>QUAL. |
|                    |
| NPI                |
|                    |
| NPI                |
|                    |
| NPI                |
|                    |
| NPI                |
|                    |
| NPI                |
|                    |
| NPI                |

**Title:** ID Qualifier [lines 1–6]

This field was originally labeled "EMG". However, "EMG" is now located in 24C.

**Instructions:** Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider is reported in 24J in the shaded area. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- E1 Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The social security number may not be used for Medicare.)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

**Description:** If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.

**Field Specification:** This field allows for the entry of a 2 character qualifier in the shaded area.

**Example:**

|                    |
|--------------------|
| I.<br>ID.<br>QUAL. |
| 1B                 |
| NPI                |

**Item Number 24J**

| J.<br>RENDERING<br>PROVIDER ID. # |
|-----------------------------------|
|                                   |
|                                   |
|                                   |
|                                   |
|                                   |
|                                   |
|                                   |
|                                   |

**Title:** Rendering Provider ID # [lines 1–6]

**Instructions:** The individual rendering the service is reported in 24J. The original fields for 24J and 24K have been combined and re-numbered as 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Enter numbers left justified in the field.

**Description:** The individual performing/rendering the service is reported in 24J and the qualifier indicating if the number is a non-NPI goes into 24I. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.

**Field Specification:** This field allows for the entry of 11 characters in the shaded area and entry of a 10 digit NPI number of the unshaded area.

**Example:**

| J.<br>RENDERING<br>PROVIDER ID. # |
|-----------------------------------|
| Z5678901234                       |
| 9876543210                        |

## Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

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

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

7 Anesthesia information  
 ZZ Narrative description of unspecified code  
 N4 National Drug Codes (NDC)  
 VP Vendor Product Number Health Industry Business Communications Council (HIBCC)  
 Labeling Standard  
 OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)  
 CTR Contract rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information

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

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

The following qualifiers are to be used when reporting NDC units:

F2 International Unit ML Milliliter  
 GR Gram UN Unit

**Please note:** The following examples are of how to enter different types of supplemental information in 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services.

### Anesthesia Services, when payment based on 15 minute units:

| 24. A. DATE(S) OF SERVICE |       |    |    |     |    | B. PLACE OF SERVICE |      | C. EMG |         | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances)<br>CPT/HCPCS   MODIFIER |    |  |  | E. DIAGNOSIS<br>POINTER |  | F. \$ CHARGES |    | G. DAYS OR UNITS |   | H. EPSOT<br>Family Plan |    | I. ID. QUAL |             | J. RENDERING<br>PROVIDER ID. # |  |
|---------------------------|-------|----|----|-----|----|---------------------|------|--------|---------|---|----|--|--|-------------------------|--|---------------|----|------------------|---|-------------------------|----|-------------|-------------|--------------------------------|--|
| MM                        | DD    | YY | MM | DD  | YY |                     |      |        |         |   |    |  |  |                         |  |               |    |                  |   |                         |    |             |             |                                |  |
| 7                         | Begin | 12 | 45 | End | 14 | 15                  | Time | 90     | minutes |   |    |  |  |                         |  |               |    |                  |   | N                       | 1B |             | 12345678901 |                                |  |
| 10                        | 01    | 05 | 10 | 01  | 05 | 22                  |      |        |         | 00770   | P2 |  |  | 134                     |  | 875           | 00 | 6                | N | NPI                     |    | 0123456789  |             |                                |  |



### Anesthesia Services, when payment based on minutes as units:

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |  |          |  | E. DIAGNOSIS<br>POINT | F. \$ CHARGES | G. DAYS<br>OR<br>UNITS | H. EPSDT<br>Family<br>Plan | I. ID.<br>QUAL. | J. RENDERING<br>PROVIDER ID. # |
|---------------------------|----|----|----|----|----|---------------------|--------|---|--|----------|--|-----------------------|---------------|------------------------|----------------------------|-----------------|--------------------------------|
| MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS   |  | MODIFIER |  |                       |               |                        |                            |                 |                                |
| 10                        | 01 | 05 | 10 | 01 | 05 | 22                  |        | 00770   |  | P2       |  | 134                   | 875 00        | 90                     | N                          | 1B              | 12345678901                    |
|                           |    |    |    |    |    |                     |        |   |  |          |  |                       |               |                        |                            | NPI             | 0123456789                     |

### Unspecified Code:

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |  |          |  | E. DIAGNOSIS<br>POINT | F. \$ CHARGES | G. DAYS<br>OR<br>UNITS | H. EPSDT<br>Family<br>Plan | I. ID.<br>QUAL. | J. RENDERING<br>PROVIDER ID. # |
|---------------------------|----|----|----|----|----|---------------------|--------|---|--|----------|--|-----------------------|---------------|------------------------|----------------------------|-----------------|--------------------------------|
| MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS   |  | MODIFIER |  |                       |               |                        |                            |                 |                                |
| 10                        | 01 | 05 | 10 | 01 | 05 | 12                  |        | E1399   |  |          |  | 12                    | 165 00        | 1                      | N                          | 1B              | 12345678901                    |
|                           |    |    |    |    |    |                     |        |   |  |          |  |                       |               |                        |                            | NPI             | 0123456789                     |

### NDC Code:

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |  |          |  | E. DIAGNOSIS<br>POINT | F. \$ CHARGES | G. DAYS<br>OR<br>UNITS | H. EPSDT<br>Family<br>Plan | I. ID.<br>QUAL. | J. RENDERING<br>PROVIDER ID. # |
|---------------------------|----|----|----|----|----|---------------------|--------|---|--|----------|--|-----------------------|---------------|------------------------|----------------------------|-----------------|--------------------------------|
| MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS   |  | MODIFIER |  |                       |               |                        |                            |                 |                                |
| 10                        | 01 | 05 | 10 | 01 | 05 | 11                  |        | J1563   |  |          |  | 13                    | 500 00        | 20                     | N                          | 1B              | 12345678901                    |
|                           |    |    |    |    |    |                     |        |   |  |          |  |                       |               |                        |                            | NPI             | 0123456789                     |

### Vendor Product Number Health Industry Business Communications Council (HIBCC):

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |  |          |  | E. DIAGNOSIS<br>POINT | F. \$ CHARGES | G. DAYS<br>OR<br>UNITS | H. EPSDT<br>Family<br>Plan | I. ID.<br>QUAL. | J. RENDERING<br>PROVIDER ID. # |
|---------------------------|----|----|----|----|----|---------------------|--------|---|--|----------|--|-----------------------|---------------|------------------------|----------------------------|-----------------|--------------------------------|
| MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS   |  | MODIFIER |  |                       |               |                        |                            |                 |                                |
| 10                        | 01 | 05 | 10 | 01 | 05 | 11                  |        | A6410   |  |          |  | 13                    | 15 00         | 1                      | N                          | 1B              | 12345678901                    |
|                           |    |    |    |    |    |                     |        |   |  |          |  |                       |               |                        |                            | NPI             | 0123456789                     |

### Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN):

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |  |          |  | E. DIAGNOSIS<br>POINT | F. \$ CHARGES | G. DAYS<br>OR<br>UNITS | H. EPSDT<br>Family<br>Plan | I. ID.<br>QUAL. | J. RENDERING<br>PROVIDER ID. # |
|---------------------------|----|----|----|----|----|---------------------|--------|---|--|----------|--|-----------------------|---------------|------------------------|----------------------------|-----------------|--------------------------------|
| MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS   |  | MODIFIER |  |                       |               |                        |                            |                 |                                |
| 10                        | 01 | 05 | 10 | 01 | 05 | 12                  |        | A6410   |  |          |  | 13                    | 500 00        | 2                      | N                          | 1B              | 12345678901                    |
|                           |    |    |    |    |    |                     |        |   |  |          |  |                       |               |                        |                            | NPI             | 0123456789                     |

### Item Number 25

|                             |                          |                          |
|-----------------------------|--------------------------|--------------------------|
| 25. FEDERAL TAX I.D. NUMBER | SSN                      | EIN                      |
|                             | <input type="checkbox"/> | <input type="checkbox"/> |

**Title:** Federal Tax ID Number

**Instructions:** Enter the provider of service or supplier federal tax ID (employer identification number) or Social Security number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

**Description:** The federal tax ID number refers to the unique identifier assigned by a federal or state agency.

**Field Specification:** This field allows for the entry of 15 characters for the Federal Tax ID Number and 1 character in either box.

**Example:**

|                             |                          |                                     |
|-----------------------------|--------------------------|-------------------------------------|
| 25. FEDERAL TAX I.D. NUMBER | SSN                      | EIN                                 |
|                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

---

### Item Number 26

|                           |
|---------------------------|
| 26. PATIENT'S ACCOUNT NO. |
|---------------------------|

**Title:** Patient's Account No.

**Instructions:** Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

**Description:** The patient's account number refers to the identifier assigned by the provider.

**Field Specification:** This field allows for the entry of 14 characters.

**Example:**

|                           |
|---------------------------|
| 26. PATIENT'S ACCOUNT NO. |
| 12341234                  |

### Item Number 27

|  |                             |
|--|-----------------------------|
| 27. ACCEPT ASSIGNMENT?<br>(For govt. claims, see back) |                             |
| <input type="checkbox"/> YES                           | <input type="checkbox"/> NO |

**Title:** Accept Assignment?

**Instructions:** Enter an X in the correct box. Only one box can be marked.

**Description:** The accept assignment indicates that the provider agrees to accept assignment under the terms of the Medicare Program.

**Field Specification:** This field allows for the entry of 1 character in either box.

**Example:**

|  |                             |
|--|-----------------------------|
| 27. ACCEPT ASSIGNMENT?<br>(For govt. claims, see back) |                             |
| <input checked="" type="checkbox"/> YES                | <input type="checkbox"/> NO |

---

### Item Number 28

|                  |  |
|------------------|--|
| 28. TOTAL CHARGE |  |
| \$               |  |

**Title:** Total Charge

**Instructions:** Enter total charges for the services (i.e., total of all charges in 24F).

Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**Description:** The total charge indicates the total billed amount for all services entered in 24F (lines 1–6).

**Field Specification:** This field allows for the entry of 7 characters to the left of the vertical line and 2 characters to the right of the vertical line.

**Example:**

|                  |         |
|------------------|---------|
| 28. TOTAL CHARGE |         |
| \$               | 1125 00 |

### Item Number 29

|                 |
|-----------------|
| 29. AMOUNT PAID |
| \$              |

**Title:** Amount Paid

**Instructions:** Enter total amount the patient or other payers paid on the covered services only.

Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**Description:** The amount paid refers to the payment received from the patient or other payers.

**Field Specification:** This field allows for the entry of 6 characters to the left of the vertical line and 2 characters to the right of the vertical line.

**Example:**

|                       |
|-----------------------|
| 29. AMOUNT PAID       |
| \$            10   00 |

---

### Item Number 30

|                 |
|-----------------|
| 30. BALANCE DUE |
| \$              |

**Title:** Balance Due

**Instructions:** Balance Due does not exist in the electronic 837 Professional 4010A1.  
Enter total amount due.

Enter number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**Field Specification:** This field allows for the entry of 6 characters to the left of the vertical line and 2 characters to the right of the vertical line.

**Example:**

|                     |
|---------------------|
| 30. BALANCE DUE     |
| \$        1115   00 |

### Item Number 31

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

**Title:** Signature of Physician or Supplier Including Degrees or Credentials

**Instructions:** Signature of Physician or Supplier Including Degrees or Credential and date does not exist in the electronic 837 Professional 4010A1.

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

**Description:** The signature of the physician or supplier including degrees or credentials refers to the authorized or accountable person and the degree, credentials, or title.

**Field Specification:** Use the space available to enter signature and date.

**Example:**

|   |                 |
|---|-----------------|
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>INCLUDING DEGREES OR CREDENTIALS<br>(I certify that the statements on the reverse<br>apply to this bill and are made a part thereof.) |                 |
| <i>Joe Smith MD</i>   | <i>09/30/05</i> |
| SIGNED  | DATE            |

### Item Number 32, 32a, and 32b

|   |    |
|---|----|
| 32. SERVICE FACILITY LOCATION INFORMATION |    |
| a. NPI                                    | b. |

#### Title 32: Service Facility Location Information

**Instructions:** Enter the name, address, city, state, and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, zip code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier.

Enter the name and address information in the following format:

- 1st Line – Name
- 2nd Line – Address
- 3rd Line – City, State and Zip Code

Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9 digit zip code, include the hyphen.

**Description:** The name and address of facility where services were rendered identifies the site where service(s) were provided.

**Field Specification:** This field allows for the entry of 78 characters in the Service Facility Location Information area.

#### Title 32a: NPI#

**Instructions:** Enter the NPI number of the service facility location in 32a.

**Description:** The NPI number refers to the HIPAA National Provider Identifier number.

**Field Specification:** This field allows for the entry of 10 characters.

#### Title 32b: Other ID#

**Instructions:** Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1A Blue Cross Provider Number

- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- TJ Federal Taxpayer's Identification Number
- X4 Clinical Laboratory Improvement Amendment Number
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

**Description:** The non-NPI ID number of the service facility refers to the payer assigned unique identifier of the facility.

**Field Specification:** This field allows for the entry of 14 characters in 32b.

**Example:**

|   |                  |
|---|------------------|
| 32. SERVICE FACILITY LOCATION INFORMATION                                 |                  |
| Physician Practice Inc<br>1234 Healthcare Street<br>Anytown IL 60610-1234 |                  |
| a. 9876543210   | b. 1BZ5678901234 |

### Item Number 33, 33a, and 33b

|   |    |
|---|----|
| 33. BILLING PROVIDER INFO & PH # (      ) |    |
| a. NPI                                    | b. |

#### Title 33: Billing Provider Info & Ph #

**Instructions:** Enter the provider's or supplier's billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

- 1st Line – Name
- 2nd Line – Address
- 3rd Line – City, State and Zip Code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9 digit zip code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.

**Description:** The billing provider's or supplier's billing name, address, zip code, and phone number refers to the billing office location and telephone number of the provider or supplier.

**Field Specification:** This field allows for the entry of the following: 3 characters for area code, 9 characters for phone number, and 87 characters in the Billing Provider Info area.

#### Title 33a: NPI#

**Instructions:** Enter the NPI number of the billing provider in 33a.

**Description:** The NPI number refers to the HIPAA National Provider Identifier number.

**Field Specification:** This field allows for the entry of 10 characters.



### Title 33b: Other ID#

**Instructions:** Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1A Blue Cross Provider Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- 1J Facility ID Number
- B3 Preferred Provider Organization Number
- BQ Health Maintenance Organization Code Number
- FH Clinic Number
- G2 Provider Commercial Number
- G5 Provider Site Number
- LU Location Number
- U3 Unique Supplier Identification Number (USIN)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

**Description:** The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.

**Field Specification:** This field allows for the entry of 17 characters in 33b.

#### Example:

|   |                  |
|---|------------------|
| 33. BILLING PROVIDER INFO & PH # ( 312 ) 5552222                          |                  |
| Physician Practice Inc<br>1234 Healthcare Street<br>Anytown IL 60610-1234 |                  |
| a. 9876543210   | b. 1BZ5678901234 |

## **APPENDIX A: ABBREVIATIONS**

AMA – American Medical Association

BLK Lung – Black Lung

CCYY – Year, indicates entry of four digits for the century (CC) and year (YY)

CHAMPUS – Civilian Health and Medical Program of the Uniformed Services

CHAMPVA – Civilian Health and Medical Program of the Department of Veterans Affairs

CLIA – Clinical Laboratory Improvement Amendments

CMS – Centers for Medicare & Medicaid Services, formerly HCFA

COB – Coordination of Benefits

CPT® – Current Procedural Terminology, 4th Edition

DD – Day, indicates entry of two digits for the day

DME – Durable Medical Equipment

EIN – Employer Identification Number

EMG – Emergency

EPSDT – Early & Periodic Screening, Diagnosis, and Treatment

F – Female

FECA – Federal Employees' Compensation Act

GTIN – Global Trade Item Number

HCFA – Health Care Financing Administration, currently CMS

HCPCS – HCFA Common Procedural Coding System

HIBCC – Health Industry Business Communications Council

HIPAA – Health Insurance Portability and Accountability Act of 1996

HMO – Health Maintenance Organization

ICD-9-CM – International Classification of Disease - Revision 9 - Clinical Modification

I.D. or ID. – Identification

ID # or ID. # – Identification Number

INFO – Information

LMP – Last Menstrual Period

M – Male

MM – Month, indicates entry of two digits for the month

NDC – National Drug Codes

No. – Number

NUCC – National Uniform Claim Committee

NUCC-DS – National Uniform Claim Committee Data Set

NPI – National Provider Identifier

OMB – Office of Management and Budget

OZ – Product number Health Care Uniform Code Council

PH # – Phone Number

QUAL. – Qualifier

REF. – Reference

SOF – Signature on File

SSN – Social Security Number

UPC – Universal Product Code

UPIN – Unique Physician Identification Number

USIN – Unique Supplier Identification Number

VP – Vendor Product Number

YY – Year, indicates entry of two digits for the year; may also be noted as CCYY, which allows for entry of four digits for the century (CC) and year (YY)

## **APPENDIX B: GUIDELINES FOR MODIFYING THE 1500 (08/05) CLAIM FORM**

The following are the National Uniform Claim Committee's (NUCC) recommended guidelines for making modifications to the 1500 (08/05) Claim Form.

### **Printer-specific/Supplier-specific Information**

Any printer-specific/supplier-specific information (e.g., logo, reorder number, phone number) that is pre-printed on the form must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page and any other pre-printed text in the margins. (See the instructions for the location of the carrier information within the carrier block of the form.)

### **Tracking Information Added By Clearinghouses, Payers, or Other Processors**

Any tracking information (e.g., time stamp, tracking number) that is added by clearinghouses, payers, or other claims processors must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page. (See the instructions for the location of the carrier information within the carrier block of the form.)

### **Barcodes**

Any barcodes added to the form, either pre-printed or during processing, must be placed in a manner in which it will not interfere with the data content of the form. Data content includes the carrier information at the top of the page. (See the instructions for the location of the carrier information within the carrier block of the form.)

### **Additional Data Elements**

The NUCC strongly discourages required or optional reporting of any data elements in addition to the data content fields on the form.

## **APPENDIX C: MAINTENANCE OF THE 1500 REFERENCE INSTRUCTION MANUAL**

### **Version Releases**

Updated versions of the 1500 Claim Form Reference Instruction Manual will be released yearly on July 1.

Any changes, clarifications, or errata will be listed on the NUCC website, at [www.nucc.org](http://www.nucc.org) under the 1500 Claim Form tab, with the issue and effective date of the change.

### **Maintenance Process**

1. Requests for clarifications or changes to the 1500 Instruction Manual should be submitted by completing the 1500 Claim Form Instructions Change Request Form (see Attachment 1 to Appendix C). The request/form can then be emailed to Nancy Spector, NUCC Chair, at [nancy.spector@ama-assn.org](mailto:nancy.spector@ama-assn.org).
2. The Data/1500 Subcommittee will review the requests for changes or clarifications to the 1500 Instruction Manual. The subcommittee's review may include any of the following:
  - coordinating the request with requirements outlined in the 837 Professional implementation guide adopted under HIPAA,
  - gaining a wider understanding of the industry's need related to the request,
  - gathering additional data, when necessary, on the overall impact of the request, and/or
  - balancing the needs of the requester versus the industry
3. The Data/1500 Subcommittee will develop a recommended response and, when appropriate, any corresponding changes to the Instruction Manual.
4. The NUCC will review the request and recommendation made by the Data/1500 Subcommittee.
5. The NUCC will make the final decision in response to the request.
6. The requester will be notified of the NUCC's final decision.
7. Final decisions may be appealed by the requester resubmitting the request along with additional supporting information.
8. If changes and/or clarifications are made to the instructions as a result of the final decision, they will be included on the NUCC's website under the 1500 Claim Form tab with the listing of changes, clarifications, and/or errata.
9. All changes, clarifications, and edits from the previous release will be incorporated into the Instruction Manual for the yearly release on July 1.

**Attachment 1 to Appendix C – 1500 Claim Form Instructions Change Request Form**

| 1500 Claim Form Instruction Change Request<br>(Provide requested information / Mark applicable box)   |        |                  |      |
|---|--------|------------------|------|
| Date:   |        |                  |      |
| <b>1. Requester Information</b>   |        |                  |      |
| Individual's Name:  |        |                  |      |
| Address (Line 1):   |        |                  |      |
| Address (Line 2):   |        |                  |      |
| City:   |        |                  |      |
| State:  |        | Zip Code         |      |
| Telephone:  |        |                  |      |
| Fax:  |        |                  |      |
| E-mail:   |        |                  |      |
| <b>2. Does this request and information provided represent the official position of a particular health care organization or a third-party payer/administrator?</b> |        |                  |      |
| Yes:  |        | No:              |      |
| If Yes, please provide<br>Organization / Entity Name:   |        |                  |      |
| <b>3. Is this request for an instruction revision or deletion?</b>  |        |                  |      |
| Revision:   |        | Deletion:        |      |
| Go to Question 4  |        | Go to Question 8 |      |
| <b>4. Specify current 1500 claim form Item # to be REVISED.</b>   | Item # |                  | Page |
| <b>5. Description of proposed revision</b>  |        |                  |      |

Check here \_\_\_\_ if continued on a separate sheet

6. Reason for proposed revision, including reasons why the existing instruction is inadequate.

---

Check here ☐ if continued on a separate sheet

7. Proposed revised instruction (text additions underlined in blue; text deletions ~~stricken through in red~~).

---

Check here ☐ if continued on a separate sheet

|  |        |  |      |  |
|--|--------|--|------|--|
| 8. Specify current 1500 claim form Item # to be DELETED. | Item # |  | Page |  |
|--|--------|--|------|--|

9. Reason for Proposed deletion, including reasons why the existing instruction is no longer appropriate.

---

Check here ☐ if continued on a separate sheet

Questions 10 through 12 apply to requests for revision or deletion.

10. Is there supporting documentation or literature that you wish to submit?

|      |  |     |  |
|------|--|-----|--|
| Yes: |  | No: |  |
|------|--|-----|--|

11. If Yes, please note how material will be submitted.

|        |  |               |  |         |  |
|--------|--|---------------|--|---------|--|
| "Fax": |  | Surface Mail: |  | E-Mail: |  |
|--------|--|---------------|--|---------|--|

12. Additional Comments:

---

Check here ☐ if continued on a separate sheet