HEALTH INSURANCE CLAIM FORM

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

aetna®

Submission Example

Please refer to the NUCC (National Uniform Claim Committee Guide) for complete detailed information on paper claim submission as well as the

837 Professional Implementation Guide for any Electronic Data Interchange (EDI) issues. http://www.nucc.org/

CARRIER

PICA	

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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 F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) (   )

ZIP CODE TELEPHONE (Include Area Code) (   )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR G...

The name of the Referring, Ordering or Supervising provider is entered in Box 17. If Box 17 is populated with a 'Name' then the qualifier must be placed in the left section of Box 17

Example – Mary Smit – Qualifiers: DN – Referring: DK – Ordering: DQ – Supervising

The providers NPI must be listed in 17b

The providers Taxonomy Code can be entered in Box 17a with the qualifier ZZ proceeding the 10 character Taxonomy Code

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PRO...

READ BAC...

12. PATIENT'S OR AUTHORIZED PE... to process this claim. I also request... below.

SIGNED DATE

SEX M F

...UCC)

...GRAM NAME

...EFIT PLAN? ...complete items 9, 9a, and 9d.

...RSON'S SIGNATURE I authorize ...undersigned physician or supplier for

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE **17a.** ZZ 1234567890 9876543210 **17b. NPI**

DN Mary Smith

Rendering Provider's Taxonomy Code is entered in Box 24J (shaded area) and the 'ZZ' qualifier in 24I NOTE: DO no populate 24J if Box 31 and 33 are the same.

18. HOSPITALIZATION DATES R... MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

The ICD Ind box must contain a valid ICD-10 code.

20. OUTSIDE LAB? YES NO

NDC – Nation Drug Code
The Provider should populate a valid NDC for drugs. The code must be entered in the shaded area of Box 24. The "N4" qualifier must precede the 11-digit NDC code. No dashes or dashes are allowed.

...below (24E) ICD Ind.

D.
H.
L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

If Rendering Provider is populated in Box 31 then the Rendering Provider's NPI is Required in Box 24j

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 | | | | | | | | | ZZ 1234567890 | NPI 0987654321

2

3

4

5

6

INFORMATION

Bill to Provider Box 33 requires mailing address (Payment).

Box 33a requires NPI of the Bill to Provider

Box 33b Taxonomy code preceded with "ZZ" qualifier to the Bill to Provider.

Service Location Box 32 – Address MUST be the physical address where the services were rendered.
Address cannot be a PO Box.
Address is required when different from the Bill to Address
Address is not required if the place of service is 12 or 115. (Home or Mobile Unit).

25. FEDERAL TAX I.D. NUMBER SSN EIN

9-Digit Federal Tax ID

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUN... $

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.)

Rendering Provider's Last Name, First Name

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Service Facility Name
Physical Location
City, State, ZIP

a. NPI of SERVICE Facility

33. BILLING PROVIDER INFO & PH # (   )

Billing Provider Name – Payment Location – City, State, Zip

a. NPI of Billing Provider ZZ qualifier – 10 digit Taxonomy

Rendering Provider's Name is required in Box 31 if different from Bill to Provider. Type Rendering Provider's name in the claims area above the preprinted 'Signed' and 'Date'.

PATIENT AND INSURED INFORMATION

...PLEASE PRINT OR TYPE... ...APPROVED OMB 0938-1197 FORM 1500 (02-12)