

Claims and Billing Manual

AmeriHealth Caritas Next and First Choice Next are individual and family health plans offered both on and off the Health Insurance Marketplace®.

AmeriHealth Caritas Next

www.amerihealthcaritasnext.com

FirstChoice Next

www.firstchoicenext.com

Effective date: October 1, 2026

AmeriHealth Caritas Next and First Choice Next are individual and family health plans offered both on and off the Health Insurance Marketplace by certain companies within the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas Next is offered by AmeriHealth Caritas VIP Next, Inc., in Delaware; AmeriHealth Caritas Florida, Inc., in Florida; AmeriHealth Caritas Indiana, Inc., in Indiana; AmeriHealth Caritas Louisiana, Inc., in Louisiana; AmeriHealth Caritas North Carolina, Inc., in North Carolina; and AmeriHealth Caritas Ohio, Inc., in Ohio. First Choice Next is offered by Select Health of South Carolina, Inc., in South Carolina.

This Provider Claims and Billing Manual is subject to change. Changes based on plan, state, or federal requirements may be made at any time.

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Introduction

AmeriHealth Caritas Next and First Choice Next, hereafter referred to as the Plans (where appropriate), are required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

Contact Information

Important Telephone Numbers

Important Contact Numbers		
Plan Name	**Provider Services Provider Claim Services EDI Technical Support**	**Pharmacy General Assistance**
AmeriHealth Caritas Next in Delaware	1-833-301-3377	1-833-733-7967
AmeriHealth Caritas Next in Florida	1-833-983-3577	1-833-981-7967
AmeriHealth Caritas Next in Indiana	1-844-280-9130	1-844-222-0317
AmeriHealth Caritas Next in Louisiana	1-833-315-2252	1-866-334-3523
AmeriHealth Caritas Next in North Carolina	1-855-266-0219	1-844-211-0968
AmeriHealth Caritas Next in Ohio	1-855-336-3077	1-844-222-6439
First Choice Next	1-833-986-7277	1-833-779-7229

Electronic Payer Identification Numbers

Electronic Payer Identification Numbers							
Plan Name	Payer ID	ConnectCenter Payer ID (CPID)		PCH Global Payer ID	Rx BIN	2026 Rx PCN	2027 Rx PCN
		Prof	Inst	Display Name: Next			
AmeriHealth Caritas Next in Delaware	47073	9426	7043	7425	028041	DEEX0812	DEEX2023
AmeriHealth Caritas Next in Florida	45408	9427	7044	7344	028041	FLEX0813	FLEX2023
AmeriHealth Caritas Next in Indiana	33372	1257	1583	N/A	028041	N/A	INEX2027
AmeriHealth Caritas Next in Louisiana	75066	3464	9006	7434	028041	LAEX0824	LAEX2026
AmeriHealth Caritas Next in North Carolina	83148	9192	6038	7412	028041	NCEX0808	NCEX2022
AmeriHealth Caritas Next in Ohio	24353	1242	1582	7448	028041	N/A	OHEX2027
First Choice Next	57103	9425	7042	7186	028041	SCEX0814	SCEX2023

Claim Mailing Addresses

Claim Mailing Addresses		
Plan Name	**Provider Claim Submission Claim Dispute Submission Provider Refunds Claim Reviews**	**Member Claim Submission Mailing Address**
AmeriHealth Caritas Next in Delaware	AmeriHealth Caritas Next Attn: Provider Claims Submission P.O. Box 7425 London, KY 40742-7425	AmeriHealth Caritas Next Attn: Member Claims Submission P.O. Box 7411 London, KY 40742-7411
AmeriHealth Caritas Next in Florida	AmeriHealth Caritas Next Attn: Provider Claims Submission P.O. Box 7344 London, KY 40742-7344	AmeriHealth Caritas Next Attn: Member Claims Submission P.O. Box 7411 London, KY 40742-7411
AmeriHealth Caritas Next in Indiana	AmeriHealth Caritas Next Attn: Provider Claims Submission P.O. Box 211051 Eagan, MN 55121	AmeriHealth Caritas Next Attn: Member Claims Submission P.O. Box 211051 Eagan, MN 55121
AmeriHealth Caritas Next in Louisiana	AmeriHealth Caritas Next Attn: Provider Claims Submission P.O. Box 7434 London, KY 40742-7434	AmeriHealth Caritas Next Attn: Member Claims Submission P.O. Box 7411 London, KY 40742-7411
AmeriHealth Caritas Next in North Carolina	AmeriHealth Caritas Next Attn: Provider Claims Submission P.O. Box 7412 London, KY 40742-7412	AmeriHealth Caritas Next Attn: Member Claims Submission P.O. Box 7411 London, KY 40742-7411
AmeriHealth Caritas Next in Ohio	AmeriHealth Caritas Next Attn: Provider Claims Submission P.O. Box 7448 London, KY 40742-7448	AmeriHealth Caritas Next Attn: Member Claims Submission P.O. Box 7411 London, KY 40742-7411
First Choice Next	First Choice Next Attn: Provider Claims Submission P.O. Box 7186 London, KY 40742-7186	First Choice Next Attn: Member Claims Submission P.O. Box 7411 London, KY 40742-7411

Use the Correct Payer ID when Filing Claims

Please be aware that the AmeriHealth Caritas Family of Companies operates numerous health plans. To promote prompt payment, please be careful to charge your claim to the correct Plan payer ID. Refer to the *Electronic Payer Identification Numbers* section of this manual.

Claim Filing

When required data elements are missing or are invalid, claims will be **rejected** by the Plan for correction and re-submission.

Claims for billable and capitated services provided to Plan members must be submitted by the provider who performed the services.

Claims filed with the Plan are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms
- Verification that all Diagnosis and Procedure Codes are valid for the date of service
- Verification of electronic claims against 837 edits from the clearinghouse
- Verification of member eligibility for services under the Plan during the time period in which services were provided
- Verification that an authorization has been given for services that require prior authorization by the Plan or that the "out-of-network" provider has received authorization to provide services to the eligible member
- All 837 claims must be compliant with SNIP level 4 standards, with the exception of provider secondary identification numbers (Provider legacy, commercial, State ID, UPIN and Location Numbers).

Rejected claims are defined as claims with invalid or required missing data elements, such as the provider tax identification number or member ID number, that are returned to the provider or EDI* source without registration in the claim processing system.

- **Rejected claims** are not registered in the claims processing system and can be resubmitted as a new claim.
- **Rejected claims** are considered original claims when resubmitted, and timely filing limits (measured from the date of service) must be followed.

Denied Claims are registered in the claims processing system but do not meet requirements for payment under Plan guidelines. Denied claims must be resubmitted as a corrected claim.

- **Denied claims** must be resubmitted as a corrected claim within 365 calendar days from the date of service.
    - Corrected and voided claims may be sent electronically or on paper.
    - The original claim number must be submitted as well as the correct frequency code:
        - You can find the original claim number from the 835 ERA, the paper Remittance Advice, or from the claim status search in NaviNet®.

- **If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to get the claim number.**
- If sent electronically, the ***claim frequency code*** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values "**7**" for the Replacement (correction) of a prior claim and "**8**" for the void of a prior claim. The value "**6**" should no longer be sent.
- In addition, the submitter must also provide the original Plan claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

The requirements outlined above apply to claims submitted on paper or electronically.

*For more information on EDI, please refer to the section title Electronic Data Interchange (EDI) within this document.

Claim Mailing Instructions

While the Plan accepts paper claims, providers are encouraged to submit claims electronically for faster, more efficient processing and payment.

If you are submitting paper claims to the Plan, refer to the *Claim Mailing Addresses* section of this manual for the appropriate state address.

Providers may submit electronic claims via Optum/Change Healthcare or Availity clearinghouses. Hereafter throughout this document we will use "Clearinghouse" to mean either Optum/Change Healthcare or Availity.

For those interested in electronic claim filing, please contact your EDI software vendor or one of the clearinghouses:

- **Optum/Change Healthcare's Provider Support Line,** available via online chat or by calling **1-800-527-8133, option 2,** Monday through Friday, 8 a.m. to 6:30 p.m., ET
- **Availity Client Services at 1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m., ET.

For any questions, call the EDI Technical Assistance phone number found in the *Important Contact Numbers* section of this manual.

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim.

Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m., ET in order to be transmitted to the Plan the next business day.

Coordination of Benefits Exceptions

When applicable, claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB (claim adjudication).

Claim Disputes

How to file a Claim Dispute

Claims Disputes may be filed electronically for the Plans through NaviNet by accessing the **Forms and Dashboards** function.

Follow these step-by-step instructions to file a Claim Dispute:

1. Log in to NaviNet.
2. Find Health Plans in the top navigation bar.
3. Select either AmeriHealth Caritas Next or First Choice Next from the drop down.
4. Navigate to the Workflows for this plan in the upper left-hand navigation menu.
5. Click on the Forms and Dashboards link.
6. Navigate to the Appeals and Claim Dispute section.
7. You will be given two choices: "Appeals on Behalf of a Member" or "Claims Dispute."
8. Select "Claims Disputes."
9. Complete the appropriate form.
10. Click submit.

Claims disputes may also be submitted in writing. Written outpatient and inpatient claim disputes must be submitted to the state appropriate address and include the correct Payer ID. Refer to the *Claim Mailing Addresses* and the *Electronic Payer Identification Numbers* section of this manual for this information.

Refunds for Claims Overpayments or Errors

The Plan's CMS and your state's Department of Insurance (DOI) encourage providers to conduct regular self-audits to ensure accurate payment.

The Plan's funds that were improperly paid or overpaid must be returned. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make arrangements to return the funds to the Plan within sixty (60) days or follow the state's protocols for returning improper payments or overpayment.

There are two ways to return overpayments to the Plan:

- Contact Provider Services to make arrangements for the Plan to deduct the overpayment/improper payment amount from future claims payments.
- Submit a check for the overpayment/improper amount directly to the address listed in the *Claim Mailing Addresses* section of this manual.

Please include the member's name and ID, date of service, and Claim ID.

Claim Form Field Requirements

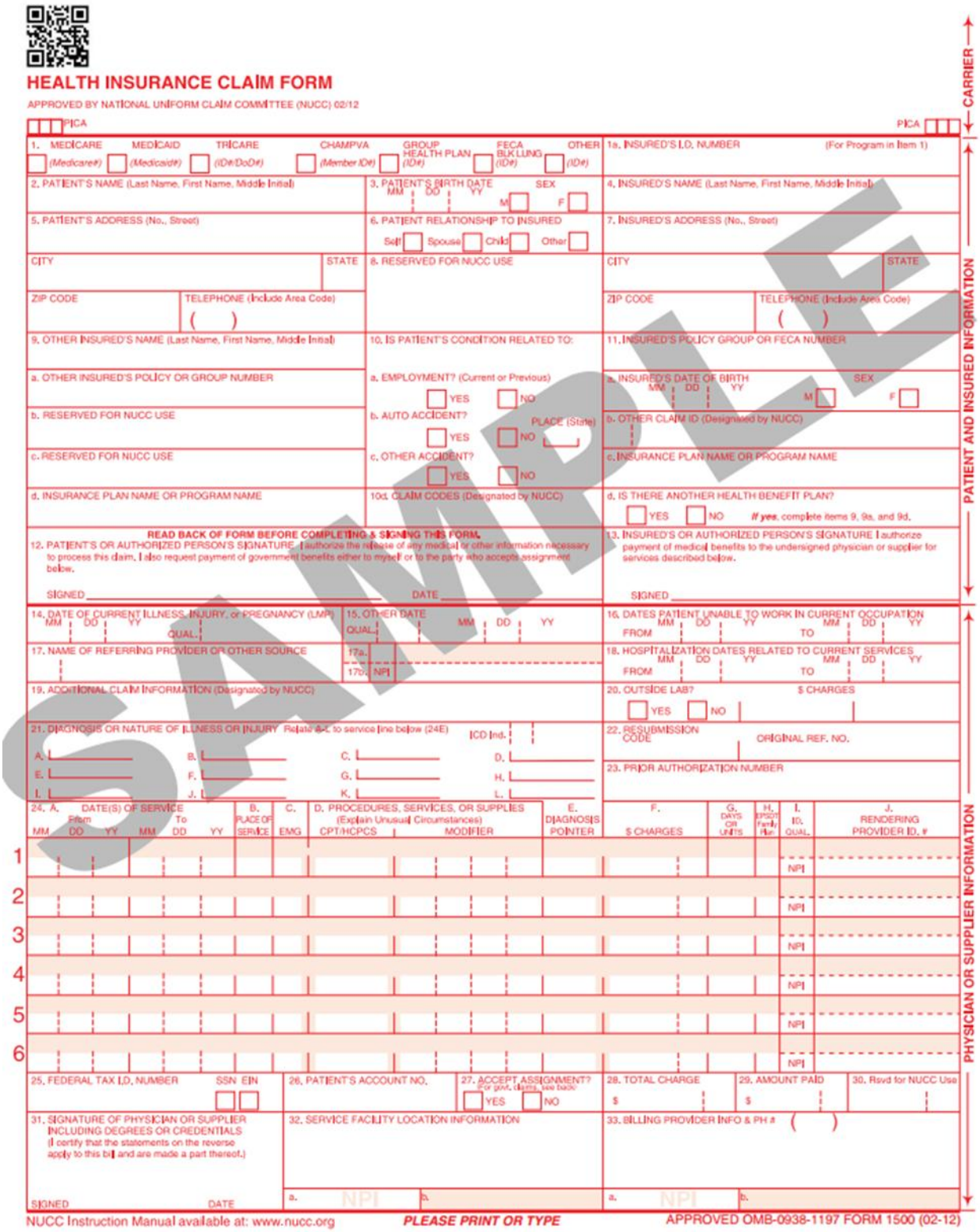
The following charts describe the required fields that must be completed for the standard Centers for Medicare & Medicaid Services (CMS) CMS 1500 or UB-04 claim forms, for claims submitted to the Plans the field is required without exception, an "R" (Required) is noted in the "Required or Conditional" box. If completing the field is dependent upon certain circumstances, the requirement is listed as "C" (Conditional) and the relevant conditions are explained in the "Instructions and Comments" box.

Refer to the National Uniform Claim Committee (NUCC) or National Uniform Billing Code (NUBC) Reference Manuals for additional information.

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. **All original/initial claims must be submitted within the required filing deadline of 180 days from the date of service**.

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

Required Fields (CMS-1500 Claim Form)



HEALTH INSURANCE CLAIM FORM

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

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 GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT 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 MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

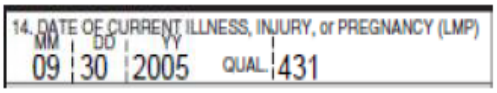
CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
N/A	**Carrier Block**			2010BB	NM103 N301 N302 N401 N402 N403	
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09	Titled Claim Filing Indicator code in 837P
1a	**Insured I.D. Number**	Health Plan's member identification number. If submitting a claim for a newborn who does not have an identification number, enter the mother's ID number. Enter the member's ID number exactly the way it appears on their Plan-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan ID card. If submitting a claim for a newborn who does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	**Patient's Birth Date / Sex**	MMDDYY / M or F If submitting a claim for a newborn, enter "newborn" and DOB/Sex.	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan ID card or enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
5	**Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	**Patient Relationship To Insured**	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P
7	**Insured's Address (Number, Street, City, State, Zip+4 Code) Telephone (Include Area Code)**	If same as the patient, enter "Same". Otherwise, enter insured's information.	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P
8	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	N/A
9	**Other Insured's Name (Last, First, Middle Initial)**	Refers to someone other than the patient. **Completion of fields 9a through 9d is Required** if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique member ID, then the patient is the subscriber and

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
						identified in this loop. Titled Other Subscriber Name in 837P
9a	**Other Insured's Policy Or Group #**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P
9b	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	Does not exist in 837P
9c	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	Does not exist in 837P
9d	**Insurance Plan Name Or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group in 837P
10 a,b, c	**Is Patient's Condition Related To:**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	R	2300	CLM11	Titled related causes code in 873P
10d	**Claim Codes (Designated by NUCC)** **Please Note:**	To comply with EPSDT reporting requirements, continue to use this field to report EPSDT referral codes as follows:	C	2300	NTE	NTE 01 position – input "ADD"

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
	EPSDT is a Medicaid program and does NOT apply to Individual and Family Health Plans offered on and off the Health Insurance Marketplace.	YD – Dental (Required for Age 3 and above) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical For all other claims enter new Condition Codes as appropriate. Available 2-digit Condition Codes include nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from, or Exacerbated by the Pregnancy Itself. • W3 – Level 1 Appeal				Upper case/capital format NTE 02 position – first six character input "EPSDT=" (upper case/capital format where the sixth character will be the = sign Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows:

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
						NTE*ADD*EPSDT=YD_YM_YO~
11	**Insured's Policy Group Or FECA #**	Required when other insurance is available. Complete if more than one other Medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line; identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P
11c	**Insurance Plan Name Or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P
11d	**Is There Another Health Benefit Plan?**	Y or N by check box If yes, indicate Y for yes. If yes, complete # 9 a-d.	R	2320		Presence of Loop 2320 indicates Y (yes) to the question on 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
12	**Patient's Or Authorized Person's Signature**	On the 837, the following values are addressed as follows at the clearinghouse: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P
13	**Insured's Or Authorized Person's Signature**		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P
14	**Date Of Current Illness Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness • 439 – Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example: 	C	2300	DTP01 DTP03	Titled in the 837P: Date – Onset of Current Illness or Symptom Date – Last Menstrual Period
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident	C	2300	DTP01 DTP03	Titled in the 837P: Date – Initial Treatment Date Date – Last Seen Date Date –

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		• 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation  Example:				Acute Manifestation Date – Accident Date – Last X-ray Date Date – Hearing and Vision Prescription Date Date – Assumed and Relinquished Care Dates Date – Property and Casualty Date of First Contact If Patient Has Had Same or Similar Illness does not exist in 837P
16	**Dates Patient Unable To Work In**		C	2300	DTP03	Titled Disability from Date and Work

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
	Current Occupation					Return Date in 837P
17	**Name Of Referring Physician Or Other Source**	**Required** if a provider other than the member's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Qualifiers include: • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider Example: 	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM 101 NM103 NM104 NM105 NM107	
17a	**Other I.D. Number Of Referring Physician**	Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: 0B State License Number 1G Provider UPIN Number	C	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if # 17 is completed.				
17b	**National Provider Identifier (NPI)**	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310D	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P
18	**Hospitalization Dates Related To Current Services**	**Required** when place of service is in-patient. **MMDDYY** (indicate **from** and **to** date)	C	2300	DPT01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
19	**Additional Claim Information** **(Designated by NUCC)**	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination. The NUCC defines the following qualifiers: • **0B** State License Number • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number *(This qualifier is used for Supervising Provider only.)* • **N5** Provider Plan Network Identification Number • **SY** Social Security Number • **X5** State Industrial Accident Provider Number • **ZZ** Provider Taxonomy	Required	2300 2310 (Rendering Provider Taxonomy)	NTE PWK PRV03	
	(837P)	**Claim Attachment Report Type codes in 837P defines the following qualifiers:** • 03 – Itemized Bill • M1 – Medical Records for Hospital-Acquired Conditions (HAC) review • 04 – Single Case Agreement (SCA)/Letter of Agreement (LOA) • 05 – Advanced Beneficiary Notice (ABN) • CK – Consent Form • 06 – Manufacturer Suggested Retail Price/Invoice • 07 - Electric Breast Pump Request Form	Required	2300	PWK01	Claim Attachment Report Type codes in 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		• 08 – Child Medical Evaluation (CME) Checklist consent forms • EB – EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter • CT – Certification of the Decision to Terminate Pregnancy • AM – Ambulance Trip Notes/ Run Sheet				
20	**Outside Lab**	If applicable, indicate Yes. (If patient had outside lab work completed.) Otherwise, leave blank.	C	2400	PS102	
21	**Diagnosis Or Nature Of Illness Or Injury. (Relate To 24E)**	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims with invalid diagnosis codes will be denied for payment. External diagnosis or "E" codes are not acceptable as a primary diagnosis.	R	2300	HIXX-02 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	
22	**Resubmission Code and/or Original Ref. No**	This field is required for resubmissions or adjustments/corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field.	C **Required** for resubmitted or adjusted claims	2300 2300	CLM05-3 REF02 Where REF01 = F8	Titled Claim Frequency Code in the 837P Titled Payer Claim Control

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		• 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim				Number in the 837P Send the original claim number if this field is used.
23	**Prior Authorization Number** **CLIA Number Locations**	Enter the referral or authorization number. Laboratory service providers must enter CLIA number here for the location. EDI claims: CLIA must be represented in the 2300 loop, REF02 element.	C	2300	REF02 Where REF01 – G1 REF02 Where REF01 = 9F REF02 Where REF01 = X4	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P Titled CLIA Number in 837P
24A	**Date(s) Of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	2400	DTP01 DTP03	Titled Service Date in 837P
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05-1 SV105	Titled Facility Code Value in 837P Titled Place of Service Code in 837P
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for	C	2400	SV109	Titled Emergency

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		"No" in the bottom (unshaded area of the field).				Indicator in 837P
24D	**Procedures, Services Or Supplies CPT/HCPCS Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. **Note:** Modifiers affecting reimbursement must be placed in the 1st modifier position. *See additional information below for EDI requirements.	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P
24E	**Diagnosis Pointer**	Diagnosis Pointer — Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107 (1-4)	Titled Diagnostic Code Pointer in 837P
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount.	R	2400	SV102	Titled Line Item Charge Amount in 837P
24G	**Days Or Units**	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits.)	R	2400	SV104	Titled Service Unit Count in 837P
24H	**EPSDT Family Plan** **Please Note:**	**In Shaded area of field:** AV - Patient refused referral;	C	2300	CRC	

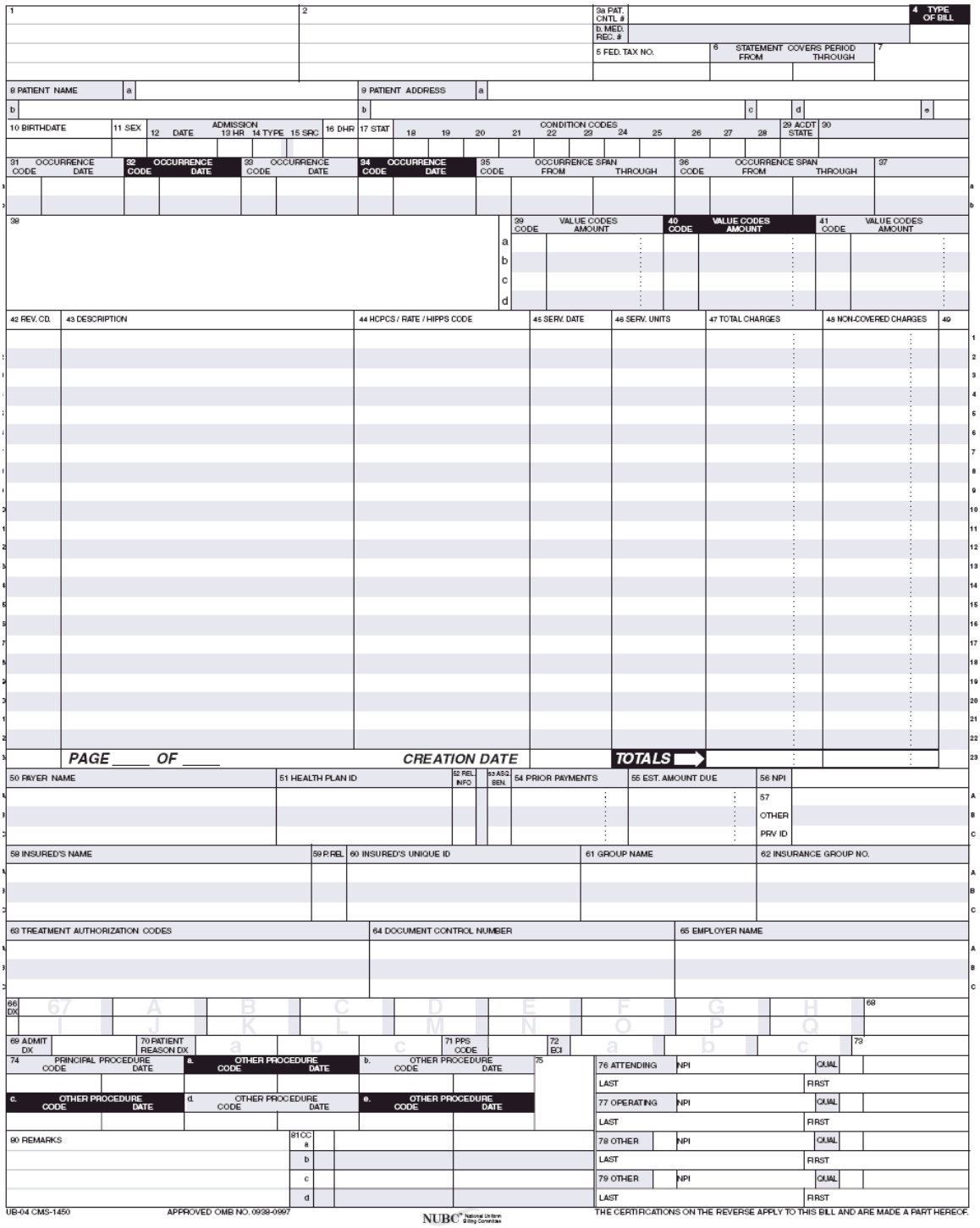
CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
	EPSDT is a Medicaid program and does NOT apply to Individual and Family Health Plans offered on and off the Health Insurance Marketplace.	S2 - Patient is currently under treatment for referred diagnostic or corrective health problems; NU - No referral given; or ST - Referral to another provider for diagnostic or corrective treatment **In unshaded area of field:** "Y" for Yes – if service relates to a pregnancy or family planning "N" for No – if service does not relate to pregnancy or family planning		2400	SV111 SV112	
24I	**ID Qualifier**	If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. • **0B** State License Number • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number If the rendering provider does have an NPI see field 24J below. If the Other ID number is the Health Plan ID number, enter G2.	R	2310B	REF (01) NM108	Titled Reference Identification Qualifier in 837P XX required for NPI in NM109
24J	**Rendering Provider ID**	The individual rendering the service is reported in 24J. Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID.	R	2310B	REF02	The clearing-house will pass this ID on the claim when present.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		Enter the NPI number in the unshaded area of the field. Use qualifier. Enter Taxonomy in shaded area: • ZZ Provider Taxonomy Box 19 can also be used for sending Rendering Provider taxonomy.			NM109 PRV03	NPI Rendering provider taxonomy
25	**Federal Tax ID Number SSN/EIN**	Physician or Supplier's Federal Tax ID numbers	R	2010AA	REF01 REF02	EI Tax SY SSN
26	**Patient's Account No.**	The provider's billing account number	R	2300	CLM01	Titled Patient Control Number in 837P
27	**Accept Assignment**	Always indicate **Yes**.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P
28	**Total Charge**	Enter charges. A value must be entered. Enter zero (0.00) or actual charges. (This includes capitated services.) Blank is not acceptable.	R	2300	CLM02	May be $0
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC Use**		Not Required			

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
31	**Signature Of Physician Or Supplier Including Degrees Or Credentials / Date**	Actual signature is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	**Required** unless #33 is the same information. Enter the physical location. **(P.O. Box #'s are not acceptable here)**	R	2310C	NM103 N301 N401 N402 N403	
32a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P
32b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended). Enter the G2 qualifier followed by the Health Plan ID #. The NUCC defines the following qualifiers used in 5010A1: • **0B** State License Number • **G2** Provider Commercial Number • **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.				
33	**Billing Provider Info & Ph. #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. Boxes are not acceptable.	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2010AA	NM109	Titled Billing Provider Identifier in 837P
33b.	**Other ID#** **(Designated by NUCC)**	Enter the Health Plan ID # (strongly recommended). Enter the G2 qualifier followed by the Health Plan ID #. The NUCC defines the following qualifiers: • **0B** State License Number • **G2** Provider Commercial Number • **LU** Location Number • **ZZ** Provider Taxonomy **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. 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.	R	2000A 2010BB	PRV03 REF02 where REF01 = G2	Titled Provider Taxonomy Code in 837P Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P

Required Fields (UB-04 Claim Form)



UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional *	Required or Conditional*	Loop	Segment	Notes
1	**Unlabeled Field** **NUBC – Billing Provider Name, Address and Telephone Number**	**Service Location, no PO Boxes** Left justified Line a: Enter the complete provider name. Line b: Enter the complete address. Line c: City, State, and Zip code + 4 Line d: Enter the area code, telephone number.	R	R	2010 AA	NM1/85 N3 N4	Billing Provider Name Billing Provider Address
2	**Unlabeled Field** **NUBC – Pay-to Name and Address**	**Enter Remit Address. No PO Boxes** Enter the Facility Provider ID number. Left justified	R	R	2010 AB	NM1/87 N3 N4	Pay-To Name Pay-To Address

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional *	Required or Conditional*	Loop	Segment	Notes
3a	**Patient Control No.**	Provider's patient account/control number	R	R	2300	CLM01	Patient's Control Number
3b	**Medical/Health Record Number**	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference Number
4	**Type Of Bill**	Enter the appropriate three or four - digit code. 1st position is a leading zero – Do not include the leading zero on electronic claims. 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates	R	R	2300	CLM05	If Adjustment or Replacement or Void claim, include frequency code as the last digit. Include the frequency code by using bill type in loop 2300. Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number (No

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		billing sequence.					dashes or spaces).
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010 AA	REF02 Where REF01 = EI	Pay to provider = Billing Prov use 2010AA. Billing Provider Tax ID
6	**Statement Covers Period From/Through**	Enter dates for the full range of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDCCYY Statement Dates
7	**Unlabeled Field**	Not Used. Leave Blank.	N/A	N/A	N/A	N/A	N/A
8a	**Patient Identifier**	Patient Health Plan ID is conditional if number is different from field 60.	R	R	2010 BA 2010 CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber Use 2010BA. Subscriber ID Patient is not =Subscriber, Use 2010CA. Patient ID
8b	**Patient Name**	Patient name is required.	R	R	2010 BA	NM103, NM104, NM107 where	Patient =Subscriber Use 2010BA.

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		Last name, first name, and middle initial. Enter the patient name as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should **not** be reported in this field. Prefix: No space should be left after the prefix of a name e.g., McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space).			2010 CA	NM101=I L NM103, NM104, NM107 where NM101 = QC	Subscriber Name Patient is not =Subscriber, Use 2010CA. Patient Name

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Conditional*	Loop	Segment	Notes
		Suffix: A space should separate a last name and suffix. Newborns and Multiple Births: If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Additional newborn billing information, including Multiple Births information, may be found within this document.					
9a-e	**Patient Address**	The mailing address of the patient	R	R	2010 BA 2010 CA	N301, N302 N401, 02, 03, 04	Patient =Subscriber, Use 2010BA.

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Conditional*	Loop	Segment	Notes
		9a. Street Address 9b. City 9c. State 9d. ZIP Code + 4 9e. Country Code (report if other than U.S.A.)				N301, N302 N401, 02, 03, 04	Subscriber Address Patient is not =Subscriber, Use 2010CA. Patient Address
10	**Patient Birth Date**	The date of birth of the patient Right-justified; MMDDYYYY	R	R	2010 BA 2010 CA	DMG02 DMG02	Subscriber Demographic Info
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care. M for male, F for female or U for unknown	R	R	2010 BA 2010 CA	DMG03 DMG03	Subscriber Demographic Info
12	**Admission Date**	The start date for this episode of care. For	R	R	2300	DTP03 where	Required on inpatient

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		inpatient services, this is the date of admission. Right Justified				DTP01=435	**Admission date/HR**
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill types other than 21X.	R	2300	DTP03 where DTP/43/	Required on inpatient. Admission date/HR
14	**Admission Type**	A code indicating the priority of this admission/visit	R	R	2300	CL101	Institutional Claim Code
15	**Point of Origin for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	Institutional Claim Code
16	**Discharge Hour**	Valid national NUBC Code indicating the discharge hour of the patient	R	R	2300	DTP03 where DTP01=096	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		from inpatient care					
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6	R	R	2300	CL103	Institutional Claim Code
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable**	C	C	2300	REF02 Where REF01 = LU	
30	**Unlabeled Field**	Leave Blank.	N/A	N/A	N/A	N/A	Reserved for future use
31a,b – 34a,b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date.	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04,	HIXX-1 = BH

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		Code must be 01 – 69, or A0-A9 or B1. Dates must be in YYYYMMDD format. **Required** when applicable				05, 06, 07, 08, 09, 10, 11, 12	
35a,b – 36a,b	**Occurrence Span Codes And Dates**	A code and the related dates that identify an event that relates to the payment of the claim. Code must be 70 – 99 or M0-Z9. Dates must be in MMDDYY format. **Required** when applicable	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BI
37a,b	**EPSDT Referral Code** **Please Note:** **EPSDT is a Medicaid program and does NOT apply to**	**Required** when applicable Enter the applicable 2-character EPSDT Referral Code for	C	C	2300	NTE	NTE 01 position – input “ADD” Upper case/capital format. NTE 02 position – first

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
	Individual and Family Health Plans offered on and off the Health Insurance Marketplace.	referrals made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above) YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical	C* C C C C C	C* C C C C C			six character input "EPSDT=" upper case/capital format where the sixth character will be the = sign. Input applicable referral directly after "=". For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~.
38	**Responsible Party Name and Address**	The name and address of the party responsible for the bill	C	C	N/A	N/A	Not required Not mapped 837I
39a,b,c,d –	**Value Codes and Amounts**	A code structure to relate amounts	C	C	2300	HIXX-2	HIXX-1 = BE

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
41a,b,c,d		or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Codes and amounts. If more than one value code applies, list in alphanumeric order. **Required** when applicable. **Note: If value code is populated then value amount must also be populated and vice versa.** Please see NUCC Specifications Manual Instructions for value codes				HIXX-5 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		and descriptions. **Documenting covered and non-covered days**: Value Code 81 – non-covered days; 82 to report co-insurance days; 83-Lifetime reserve days. Code in the code portion and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.					
42	**Rev. Cd.**	Codes that identify specific accommodation, ancillary service or unique billing	R	R	2400	SV201	Revenue Code

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		calculations or arrangements. Hospital: Enter the rev code that corresponds to the rev description in field 43. Refer to NUBC for valid rev codes. The last entry on the claim detail lines should be 0001 for total charges. PPED: Use the rev code that appears on the approved prior authorization letter for covered services. LTC state facility: Use rev code 0100 for room and board, plus ancillary					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		LTC non-state/assisted living: Use rev code 0101 for room and board, without ancillary. Use appropriate rev code for covered ancillary service. Leave of Absence codes: LTC – state and non-state facilities: Use LOA rev codes 0183, 0185 and 0189 as appropriate. Assisted Living Facilities: Use only 0189 as a LOA code, no payment is made for days billed with rev code 0189. Use for any days when patient is out of the facility					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		for the entire day.					
43	**Revenue Description**	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category. Use this field to enter NDC information. Refer to supplemental information section.	R	R	N/A	N/A	Not mapped 837I
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	1. The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary	R	R	2400	SV202-2	SV202-1=HC/HP

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Conditional*	Loop	Segment	Notes
		service and outpatient bills 2. The accommodation rate for inpatient bills 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Enter the applicable rate, HCPCS or HIPPS code					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. (Note: NDC numbers are required for all administered or supplied drugs.)					
45	**Serv. Date**	Report line item dates of service for each revenue code or HCPCS/HIPPS code. Multiple-day service codes require an RR modifier.	R	R	2400	DTP03 where DTP01=472	Date of Service
46	**Serv. Units**	Report units of service. A quantitative measure of services rendered by revenue	R	R	2400	SV205	Service Units

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Note: For drugs, service units must be consistent with the NDC code and its unit of measure. NDC unit of measure must be a valid HIPAA UOM code or the claim may be rejected.					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
47	**Total Charges**	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges. Report grand total of submitted charges. Enter a zero ($0.00) or actual charged amount.	R	R	2300	SV203	Total Charges
48	**Non-Covered Charges**	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code.	C	C	2400	SV207	Non-Covered Charges

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
49	**Unlabeled Field**	N/A	Not required	Not required	N/A	N/A	N/A
50	**Payer**	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2000 B 2010 BA 2320 2330 B	SBR NM103 where NM101=P R SBR NM103 where NM101=P R	Subscriber Information Payer Name Other Subscriber Information Other Payer Name
51	**Health Plan Identification Number**	The number used by the health plan to identify itself (Payer ID).	R	R	2330 B	NM109 where NM101=P R	Payer ID
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on	R	R	2300	CLM09	Release of Information code

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Conditional*	Loop	Segment	Notes
		Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider have all necessary release information on file. It is expected that all released invoices contain "Y".					
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C	R	R	2300	CLM08	Benefits Assignment Certification Indicator

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Conditional*	Loop	Segment	Notes
		refers to the tertiary.					
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01=D	Prior Payment Amounts
55	**Est. Amount Due**	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage). The AMT field should be in the format XXXX-XX (up to two decimal places).	C	C	2300	AMT02 where AMT01 =EAF	Payment Estimated Amount Due

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
56	**National Provider Identifier – Billing Provider**	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. **Required** if the health care provider is a Covered Entity as defined in HIPAA Regulations	R	R	2010 AA	NM109 where NM101 = 85	NPI
57 A,B,C	**Other (Billing) Provider Identifier**	A unique identification number assigned to the provider submitting the bill by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by	C	C	2010 AA 2010 BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U	Tax ID Only sent if needed to determine the Plan ID Legacy ID

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		the health plan listed in Field 50 A, B and C.					
58	**Insured's Name**	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.	R	R	2010 BA 2330 A	NM103, NM104, NM105 where NM101 = IL NM103, NM104, NM105 where NM101 = IL	Use 2010BA if insured is subscriber. Other Insured Name
59	**P. Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000 B	SBR02	Individual Relationship code
60	**Insured's Unique Identifier**	Enter the patient's Health Plan ID on the	R	R	2010 BA	NM109 where	Insured's Unique ID

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		appropriate line, exactly as it appears on the patient's ID card on line B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.				NM101= IL REF02 where REF01 = SY	
61	**Group Name**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000 B	SBR04	Subscriber Group Name
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group	C	C	2000 B	SBR03	Subscriber Group or Policy Number

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.					
63	**Treatment Authorization Codes**	Enter the Health Plan referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number
64	**DCN**	Document Control Number. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously,	C	C	2320	REF02 where REF01 = F8	Original Claim Number

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		field 64 contained the Employment Status Code. The ESC field has been eliminated. **Note:** Resubmitted claims must contain the original claim ID.					
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer;	C	C	2320	SBR04	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		B, secondary; and C, tertiary.					
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported.	Not Required	Not Required	2300	Determined by the qualifier submitted on the claim.	Not Required
67	**Prin. Diag. Cd. and Present on Admission (POA) Indicator**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current	R	R	2300	HIXX-2 HIXX-9 Where HI01-1 = ABK	Principal Diagnosis POA

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		hospital service.					
67 A - Q	**Other Diagnosis Codes**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = ABF	Other Diagnosis Information
68	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
69	**Admitting Diagnosis Code**	The appropriate ICD code	R	R	2300	HI01-2	Admitting diagnosis

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		describing the patient's diagnosis at the time of admission as stated by the physician. **Required** for inpatient and outpatient				Where HI01-1= ABJ	
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2 **Where HIXX-1=APR** **Where XX = 01, 02, 03**	Patient reason for visit
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the claim to identify the DRG based on the grouper	C	C	2300	HI01-2 Where HI01-1 = DR	DIAGNOSIS Related Group (DRG) Information

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.					
72a-c	**External Cause of Injury (ECI) Code**	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C	2300	HIXX-2 Where HIXX-1 = ABN	External Cause of Injury
73	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
74	**Principal Procedure code and Date**	The appropriate ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date **Inpatient facility** – Surgical procedure code is required if the operating room was used. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical	C R	C R	2300	HI01-2 HI01-4 Where HI01-1 = BBR	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		procedure is performed.					
74a-e	**Other Procedure Codes and Dates**	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. **Inpatient facility** – Surgical procedure code is required when a surgical procedure is performed. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD	C C	C C	2300	HIXX-2 Where HI01-1 = BBQ	Other Procedure Information

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		code is required when a surgical procedure is performed.					
75	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
76	**Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#**	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first	R	R	2310 A 2310 A 2310 A 2301 A	NM109 where NM101 = 71 REF02 NM103 where NM101=71	REF01=G2/

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		name of the Attending Physician. Note: If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject. ZZ Attending Provider Taxonomy				PRV01 PRV03	Attending Provider Taxonomy
77	**Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#**	**Enter the** NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating	C	C	2310 B	NM103, NM104, NM107, NM109 where NM101 = 72 REF02 where	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. Required when a surgical procedure code is listed.				REF01 = G2	
78 – 79	**Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#**	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient's medical care or treatment in the upper line, and their	R	R	2310 C 2310 C	NM103, NM104, NM107, NM109 where NM101 = ZZ REF02where REF01 = G2	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#.					
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim **Claim Attachment Report Type codes in 837I** defines the following qualifiers 03 – Itemized Bill	C R	C R	2300 2300	NTE02 Where NTE01=ADD PWK01	Billing Note Claim Attachment Report Type codes in 837I

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		M1 – Medical Records for Hospital-Acquired Condition (HAC) review 04 – Single Case Agreement (SCA)/Letter of Agreement (LOA) 05 – Advanced Beneficiary Notice (ABN) CK – Consent Form 06 – Manufacturer Suggested Retail Price /Invoice 07 – Electric Breast Pump Request Form 08 – Child Medical Evaluation (CME)					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		Checklist consent forms EB – EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT – Certification of the Decision to Terminate Pregnancy AM – Ambulance Trip Notes/ Run Sheet					
81CC, a-d	**Code-Code Field**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the	C	C	2000 A	PRV01 PRV03	Billing Provider Taxonomy

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional *	Required or Condition al*	Loop	Segment	Notes
		institutional data set. B3 Billing Provider Taxonomy					

Special Instructions and Examples for CMS 1500, UB-04 and EDI Claim Submissions

CMS 1500 Paper Claims – Field 24

All unspecified Procedure or HCPCS codes require a narrative description be reported in the shaded portion of field 24. The shaded area of lines 1 through 6 allows for the entry of 61 characters from the beginning of 24A to the end of 24G.

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24 (or 2410/LIN and CTP segments when submitting via 837):

- 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.

Qualifiers	Service
7	Anesthesia information
ZZ	Narrative description of unspecified code (All miscellaneous fields require this section be reported.)

N4	National Drug Codes
VP	Vendor Product Number Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
CTR	Contract rate

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.

EDI – Field 24D (Professional)

Details pertaining to Anesthesia Minutes and corrected claims may be sent in Notes (NTE).

- Details sent in NTE that will be included in claim processing:
  - Please include L1, L2, etc. to show line numbers related to the details. Please include these letters AFTER those specified below:
    - Anesthesia Minutes need to begin with the letters ANES, followed by the specific times.
    - Corrected claims need to begin with the letters RPC, followed by the details of the original claim.
    - DME claims requiring specific instructions should begin with DME, followed by specific details.

EDI – Field 33b (Professional)

Field 33b – Other ID# – Professional: 2310B loop, REF01=G2, REF02+ Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required.

Note: Do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims.

EDI – Field 45 and 51 (Institutional)

Field 45 – **Service Date** must not be earlier than the claim statement date.

Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – **Health Plan ID** – the Payer ID number used by the health plan to identify itself. Refer to the *Electronic Payer Identification Numbers* section of this manual.

EDI – Reporting DME

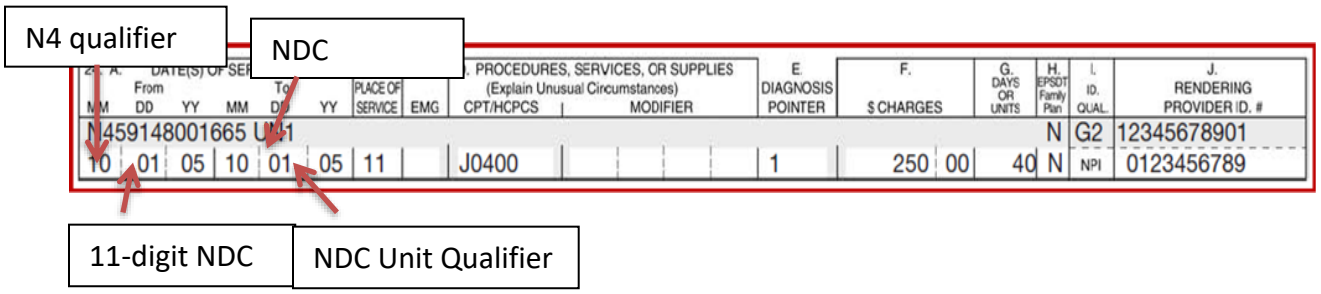
DME Claims requiring specific instructions should begin with DME followed by specific details.
Example: NTE*ADD*DME AEROSOL MASK, USED W/DME NEBULIZER

Reporting NDC on CMS-1500 and UB-04 and EDI

NDC on CMS 1500

- NDC must be entered in the shaded sections of item 24A through 24G.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11-digit NDC information:
    - Do not enter a space between the qualifier and the 11-digit NDC number.
    - Enter the 11-digit NDC number in the 5-4-2 format (no hyphens).
    - Do not use 99999999999 for a compound medication; bill each drug as a separate line item with its appropriate NDC.
- Enter the NDC quantity unit qualifier:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN – Unit
- Enter the NDC quantity:
    - Do not use a space between the NDC quantity unit qualifier and the NDC quantity.
    - Note: The NDC quantity is frequently different than the HCPC code quantity.

Example of entering the identifier N4 and the NDC number on the CMS 1500 claim form:



NDC on UB-04

- NDC must be entered in Form Locator 43 in the Revenue Description Field.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- Report the N4 qualifier in the first two (2) positions, left-justified.
    - Do not enter spaces.
    - Enter the 11-character NDC number in the 5-4-2 format (no hyphens).
    - Do not use 99999999999 for a compound medication; bill each drug as a separate line item with its appropriate NDC.
- Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter

    - UN – Unit
    - ME – Milligram
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
    - Any unused spaces for the quantity are left blank.

Note: The decision to make all data elements left-justified was made to accommodate the largest quantity possible. The description field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below:

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	4	5	.	5	6	7	

NDC via EDI
The NDC is used to report prescribed drugs and biologics as required by government regulation.

EDI claims with NDC info must be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDCs sent at claim line level should be submitted using CMS-1500 or UB-04 paper claim.

When submitting NDC in the LIN segment, the CTP segment is required. This segment is to be submitted with the Unit of Measure and the Quantity.

When submitting this segment, CTP03, Pricing; CTP04, Quantity; and CTP05, Unit of Measure are required.

Provider Preventable Conditions Payment Policy and Instructions

Submission of POA Indicators for Primary and Secondary Diagnoses

The Plan payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. It is the Plan's policy to deny payment for PPCs.

Health Care Acquired Conditions (HCAC) apply to the Plan's inpatient hospital settings. An HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D) of the Social Security Act. HCACs presently include the full list of

Medicare's ACA hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

Other Provider-Preventable Conditions (OPPC) are more broadly defined to include inpatient and outpatient settings. An OPPC is a condition occurring in any health care setting and includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs (surgery on the wrong patient, surgery on the wrong site, or wrong surgery on the patient).

The Plans refer to HCACs and OPPCs collectively as PPCs or "never events." The Plans will not reimburse providers for never events.

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment claim adjustments. That is, a PPC must be reported by the Provider at the time a claim is submitted.

There are some circumstances under which a PPC adjustment will not be taken or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the Provider. Please refer to the Reporting POA sections that follow for details.
- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment and the Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

Practitioner/Dental Providers

If a PPC occurs, providers must report the condition through the claims submission process. Note: This is required even if the Provider does not intend to submit a claim for reimbursement for the services. The requirement applies to providers submitting claims on the CMS-1500 or 837-P forms, as well as dental providers billing via ADA claim form or 837D formats.

For professional service claims, please use the following claim type and format:

Claim Type:

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient), or PC (wrong site surgery) in 24D of the CMS 1500 claim form.
- Dental providers must report a PPC on the paper ADA claim form using modifier PA, PB, or PC on the claim line, or report modifiers PA, PB, or PC in the remarks section or claim note of a dental claim form.

Claim Format:

- Report the external cause of injury codes, such as Y65.51, Y65.52, or Y65.53 in field 21 [and/or] field 24E of the CMS 1500 claim form.

Inpatient/Outpatient Facilities

Facility providers must report a PPC via the claim submission process. Note: this reporting is required even if the Provider does not intend to submit a claim for reimbursement of the services. This requirement applies to providers who bill inpatient or outpatient services via UB-04 or 837I formats.

For Inpatient Facilities

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.** When submitting a claim which includes treatment as a result of a PPC, facility providers are to include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury on the claim in field 67 A – Q. Examples of ICD-10 and external cause of injury include:

- Wrong surgery on correct patient Y65.51
- Surgery on the wrong patient, Y65.52
- Surgery on wrong site Y65.53
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired.”

For per-diem or percent of charge based hospital contracts, claims including a PPC must be submitted via paper claim with the patient’s medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrently with the claim. All information, including the patient’s medical record and paper claim should be sent to the address found in the *Claim Mailing Addresses* section of this manual.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC DRG. Facilities need not submit copies of medical records for PPCs associated with this payment type.

For Outpatient Providers

Outpatient facility providers submitting a claim that includes treatment required because of a PPC must include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury on the claim in field 67 A – Q. Examples of ICD-10 and external cause of injury codes include:

- Wrong surgery on correct patient Y65.51
- Surgery on the wrong patient, Y65.52
- Surgery on wrong site Y65.53

UB-04 or 837I

Valid POA indicators are as follows, blanks are not acceptable:

- “Y” = Yes = present at the time of inpatient admission
- “N” = No = not present at the time of inpatient admission
- “U” = Unknown = Documentation is insufficient to determine if condition was present at time of inpatient admission.

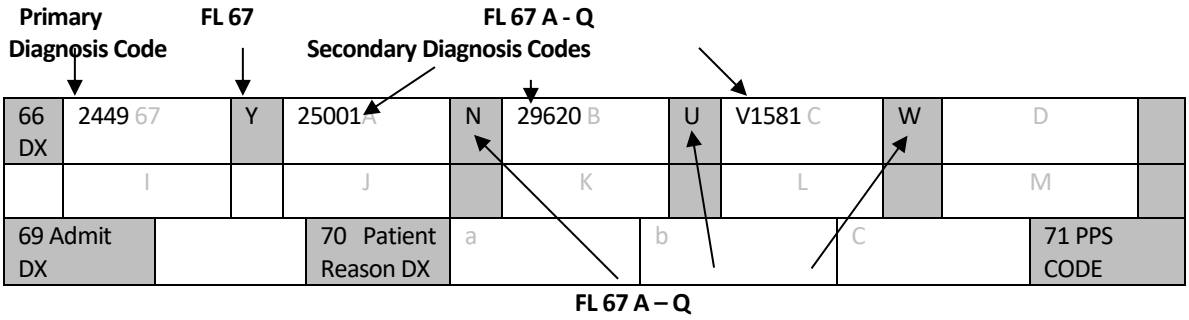
- "W" = Clinically Undetermined = Provider is unable to clinically determine whether condition was present at time of inpatient admission or not.
- 1 = exempt from POA reporting for paper claims
- Blank = exempt from POA reporting for electronic claims

A. Reporting POA on the UB-04 Claim Form

Fields 67 A – Q:

- Valid primary and secondary diagnosis codes (up to 5 digits) are to be placed in the unshaded portion of 67 A – Q, followed by the applicable POA indicator (1 character) in the shaded portion of 67 A – Q.

Sample UB-04 populated with primary and secondary diagnosis codes, and POA indicators:



B. Reporting POA in Electronic 837I Format

Provider is to submit their POA data via the NTE segment on all 837I claims.

- Although this segment can repeat, the Plans require that the provider submit POA data on a single NTE Segment. No additional NTE segments with the letters POA will be validated.
- NTE01 must contain POA as the first three characters or the POA data will not be picked up: NTE*POA~.
- NTE segment must only contain details pertaining to the Principal and Other Diagnosis found in the HI segment with qualifiers BK for Principal and BF for Other Diagnosis prior to the ending Z (or X).
- The POA indicator for the BN – External Cause of Injury on the NTE segment with POA is entered following the ending Z (or X).
- No POA Indicator is to be sent for the BJ/ZZ – Admitting Diagnosis Data. 1, Y, N, U, W are valid, with ending characters of X or Z and E Code indicator.

  Example:
  1st claim:
  1 Principal and 2 Other Diagnosis
  NTE*ADD*POAYNUZ~

  2nd Claim:
  1 Principal and 3 Other Diagnosis and an E-Code
  NTE*ADD*POAYYNIZY~

Common Causes of Claim Processing Delays, Rejections, or Denials

Authorization Invalid or Missing – A valid authorization number must be included on the claim form for all services requiring prior authorization.

Attending Physician ID Missing or Invalid – Inpatient claims must include the name of the physician who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (Attending Physician ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as 2 alpha, 6 numeric, and 1 alpha character (AANNNNNNA) or 2 alpha and 6 numeric characters (AANNNNNN).

Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.

Diagnosis Code Missing Required Digits – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM or ICD-10 manual for the appropriate categories, subcategories, and extensions. Refer to the coding manuals to determine when additional alpha or numeric digits are required. Use "X" as a place holder where fewer than seven digits are required. Submit the correct ICD qualifier to match the ICD code being submitted.

Diagnosis, Procedure or Modifier Codes Invalid or Missing – Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG codes must include this information on the claim form.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations, and messages. Payment from the previous payer may be submitted on the 837I or 837P. Besides the information supplied in this document, the line item details may be sent in the SVD segment. Include the adjudication date at the other payer in the DTP, qualifier 573. COB pertains to the other payer found in 2330B.

External Cause of Injury Codes – External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Include applicable POA Indicators with ECI codes.

Future Claim Dates – Claims submitted for Medical Supplies or Services with future claim dates will be denied, for example, a claim submitted on October 1 for bandages that are delivered for October 1 through October 31 will deny for all days except October 1.

Handwritten Claims – Handwritten claims are not accepted. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity.

Highlighted Claim Fields (See Illegible Claim Information)

Illegible Claim Information – Information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed in black ink, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate.

Incomplete Forms – All required information must be included on the claim forms in order to ensure prompt and accurate processing.

Member Name Missing – The name of the member must be present on the claim form and must match the information on file with the Plan.

Member Plan Identification Number Missing or Invalid – The Plan's assigned identification number must be included on the claim form or electronic claim submitted for payment.

Member Date of Birth does not match Member ID Submitted – A newborn claim submitted with the mother's ID number will be pended for manual processing causing delay in prompt payment.

Newborn Claim Information Missing or Invalid – Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert "Baby Girl" or "Baby Boy" in front of the mother's last name as the baby's first name. Verify that the appropriate last name is recorded for the mother and baby.

Payer or Other Insurer Information Missing or Incomplete – Include the name, address, and policy number for all insurers covering the Plan member.

Place of Service Code Missing or Invalid – A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.

Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Spanning Dates of Service Do Not Match the Listed Days/Units – Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

Signature Missing – The signature of the practitioner or provider of service must be present on the claim form and must match the service provider name, NPI and TIN on file with the Plan.

Tax Identification Number (TIN) Missing or Invalid – The Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with the Plan.

Taxonomy – The provider's taxonomy number is required wherever requested in claim submissions.

- CMS-1500 field 19 (Rendering Taxonomy) and 33b (Billing Taxonomy)
- UB-04 field 76 (Attending Taxonomy) and 81 (Billing Taxonomy)

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

- **Reminder:** When billing Electronic Data Interchange (EDI) 837 coordination of benefit services to the Plan as a secondary payer for a member that has traditional Medicare or a Medicare Advantage plan, indicate the appropriate primary insurer. Claims submitted indicating the primary payer is a commercial carrier rather than Medicare may be delayed or processed incorrectly.
- **Correct EDI submission:** The claims filing indicator (located in Loop 2320, segment SBR09) identifies whether the primary payer is Medicare or another commercial payer. When the member has a Medicare Advantage plan, the claim should be billed to the secondary payer with a Medicare Part A or B indicator, not as commercial insurance. Please ensure you are using the appropriate indicator on EDI claims as follows:
    - MA — The primary payer is Medicare Part A. (Use for both traditional Medicare and Medicare Advantage.)
    - MB — The primary payer is Medicare Part B. (Use for both traditional Medicare and Medicare Advantage.)
    - CI — The primary payer is commercial insurance (non-Medicare).

Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims. Adjusted claims may be sent via paper or EDI.



IMPORTANT BILLING REMINDERS:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections, or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State-level HCPCS coding takes precedence over national-level codes unless otherwise specified in individual provider contracts.

- Append the appropriate modifiers to the HCPCS/CPT code when performing a service or separate, distinct, or independent procedure on the same day that a procedure or other service is performed. Refer to the American Medical Association (AMA) CPT Code book for coding guidelines.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit the claim with the appropriate coding that matches the total charges on the EOB.
- Submitting the original copy of the claim form will assist in ensuring claim information is legible.
- Reimbursement for all rendering network providers subject to the ordering/referring/prescribing (ORP) requirement for an approved authorization is determined by satisfying the mandatory requirement to have a valid member ID. Any claim submitted by rendering network providers that are subject to the ORP requirement will be denied when billed with the NPI of an ORP provider that is not enrolled in the Plan.
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- Although the newborn claim is submitted under the mother's ID, the claim must be processed under the baby's ID. The claim will not be paid until the state confirms eligibility and enrollment in the plan.
- The claim for the baby *must* include the *baby's date of birth,* as opposed to the mother's date of birth. The claim must also include the *baby's birth weight (value code 54)*.
- On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith *A*, Baby Girl Smith *B*, etc.
- For coordination of benefits claims, dates of service and billed charges should exactly match the services and charges detailed on the primary insurer's EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit the claim with the appropriate coding that matches the total charges on the EOB.
- The *individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. An imprecise use of NPI number results in inaccurate payments or denials.
- When submitting electronically, the provider NPI number must be entered at the claim level, as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.

- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.
- Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.

Electronic Data Interchange (EDI) for Medical and Hospital Claims

Electronic Data Interchange (EDI) allows faster, more efficient, and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.
The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing.

Please allow for normal processing time before resubmitting the claim either through EDI or paper claim. This will reduce the possibility of your claim being rejected as a duplicate claim.

In order to verify satisfactory receipt and acceptance of submitted records, please review both the clearinghouse acceptance report, and the R059 Plan Claim Status Report.

Refer to the Claim Filing section of this document for general claim submission guidelines.

Electronic Claims Submission (EDI)

Electronic Claims

If you have the capability to send EDI claims to our clearinghouses, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically to the Plan. The Plan does not require enrollment with one of our clearinghouses in order to submit EDI claims to the Plan.

Electronic claim submissions to the Plan should follow the same process as other electronic commercial submissions.

To Initiate Electronic Claims Submissions

- Read over the instructions within this manual carefully, with special attention to the information on exclusions, limitations, and especially the rejection notification reports.
- Contact your practice management software vendor or EDI software vendor.
- Inform your vendor of the Plan's EDI Payer ID number. Refer to the Electronic Payer Identification Numbers section of this manual.

If you do not have another clearinghouse/EDI software vendor, you can submit your claims electronically through one of our clearinghouses by contacting:

- **Optum/Change Healthcare's Provider Support Line,** available via online chat or by calling **1-800-527-8133, option 2,** Monday through Friday, 8 a.m. to 6:30 p.m., ET
- **Availity Client Services at 1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m., ET.

Submitting Manual/Direct Entry Claims

Providers who have limited ability to submit claims through their practice management or hospital information systems may also submit manual or direct-entry claims through Optum/Change Healthcare or PCH Global. Please note that PCH Global is not available for all plans.

Optum/Change Healthcare ConnectCenter™

Providers may submit manual or direct entry claims at no cost, through ConnectCenter.

- Access the login page via the Claims submission link in the NaviNet provider portal or via ConnectCenter to complete your provider registration. If prompted for a Vendor code use: **214629**. Note: This URL is specific to new provider registration only.
- Follow the instructions on the login page to establish your password and to set up the required multi-factor authentication.
- When creating/uploading batch claims, a 4-digit ConnectCenter payer identifier (CPID) must be used to identify which plan is being billed. The CPIDs for the Plans are listed in the *Electronic Payer Identification Numbers* section of this manual.
- For user guides and tutorials on how to navigate ConnectCenter, visit www.amerihealthcaritasnext.com > Pick Your State > Claims, Billing, and Payment > Optum/Change Healthcare ConnectCenter electronic claim user guides.
- If you need further assistance, **Optum/Change Healthcare's ConnectCenter Provider Support Line** is available through online chat or by calling **1-800-527-8133, option 2,** Monday through Friday, 8 a.m. to 6:30 p.m., ET.

PCH Global

You may also submit manual or direct entry claims at no cost, through PCH Global. To enroll for claims submission, please go to PCH Global and click the *Sign-Up* link in the upper right-hand corner.

Complete the registration process and log into your account:

- You will be asked how you heard about PCH Global. **Select** Payer, then AmeriHealth.
- Access your profile by clicking on Manage User and then My Profile.
- You will need to complete all the profile information. When you go to the Subscription Details screen, select the More option on the right-hand side to see how to enter the promo code **Exela-EDI**.

When you are ready to submit claims, refer to the *Electronic Payer Identification Numbers* section of this manual to search for your payer ID information.

For a detailed walk through of the registration process, refer to the PCH Global Registration manual, found on the PCH Global website in the Resource Menu.

PCH Global customer support is available at **1-888-988-0605**, Monday through Friday, 8 a.m. to 8 p.m., ET. Any additional questions may be directed to the Plan's EDI Technical Assistance line. Refer to the *Important Contact Numbers* section of this manual for your state specific phone number.

ConnectCenter and PCH Global will automatically edit and validate claims for HIPAA compliance and will forward them directly to the Plan.

Electronic Claim Hardware/Software Requirements

There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to a clearinghouse, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Please note, providers using Optum/Change Healthcare, Availity, or other clearinghouses and vendors are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Note**:** The Payer ID for the Plans can be found in the *Electronic Payer Identification Numbers* section of this manual.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this manual. Optum/Change Healthcare, Availity, or any other EDI clearinghouse or vendor may require additional data record requirements.

Electronic Claim Flow Description

All Plan claims will be routed through Optum/Change Healthcare or Availity by your vendor/clearinghouse, which may be an existing process utilized today by your practice. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once the clearinghouse receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits. Claims not meeting the requirements are immediately rejected and sent back to the sender via an error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or clearinghouse.

Accepted claims are passed to the Plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to the Plan by the clearinghouse are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to the clearinghouse, which also forwards this rejection to its trading partner – the intermediate EDI vendor or provider. Claims passing eligibility requirements are then passed to the claim processing queues. **Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.**

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse or other contracted EDI software vendors must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to the Plan. If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)** .

If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact EDI Technical Assistance at the phone number found in *Important Contact Numbers* section of this manual.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

The clearinghouse will produce an Acceptance report* and a R059 Plan Claim Status Report** for *its* trading partner whether that is the EDI vendor or provider. You are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments.

*An Acceptance report verifies acceptance of each claim at the clearinghouse.

**An R059 Plan Claim Status Report is a list of claims that passed the clearinghouse's validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

About Timely Filing

Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Your claims must be received by the EDI vendor by 9 p.m., ET in order to be transmitted to the Plan the next business day.

Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or clearinghouse to verify you receive the reports necessary to obtain this information.

When you receive the Rejection report from the clearinghouse or your EDI vendor, the plan does not receive a record of the rejected claim.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass the clearinghouse HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 365 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from the clearinghouse or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically:

- 837P – 005010X222A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- 837I – 005010X223A2 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Please note, provider NPI number validation is not performed at the clearinghouse. The clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

The Plan's Provider ID is recommended as follows:

- 837P – Loop 2310B, REF*G2[PIN]
- 837I – Loop 2310A, REF*G2 [PIN]

Exclusions

Certain claims are excluded from electronic billing.

Excluded Provider Categories: Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through a clearinghouse or providers sending to Vendors that are not transmitting through a clearinghouse NCPDP Claims

Common Electronic Rejections

Invalid Electronic Claim Records – Common Rejections
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)

Claims without provider numbers
Claims without member numbers
Claims in which the date of birth submitted does not match the member ID

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers
Claims received with invalid member numbers
Claims received with invalid member date of birth
Claims without Billing Taxonomy IDs, Attending Taxonomy IDs, Rendering Taxonomy IDs

Best Practices for Submitting Corrected Claims

Corrected claims are resubmissions of an existing claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes, or billed amounts. It is not a request to review the processing of a claim. The successful submission of a corrected claim will cause the retraction and complete replacement of the original claim.

A corrected claim should only be submitted for a claim that has already been processed and you need to correct information on the original submission.

Electronic data interchange (EDI) is the preferred method for submitting corrected claims due to its speed, versatility, and accuracy.

How do I know when to file a new claim vs. a corrected claim?

File a New Claim When:

- The claim was never previously billed.
- No payment was received. If the entire claim allows zero dollars, make the appropriate changes and resubmit as a new claim. **Do not submit as a corrected claim.**
- You received a rejection letter to a paper claim indicating invalid or required missing data elements, such as the provider tax identification number or member ID number.
- You received a rejection notice at your electronic claim clearinghouse (277CA) indicating invalid or missing a required data element.
- The original claim denied for primary carrier EOB, and now you have the primary carrier EOB.
- The claim denied for eligibility, and now the eligibility has been updated and the member has active coverage.
- You submitted a claim for the wrong member. Submit a frequency code 8 to request a void of the original submission, then submit a new claim.

File a Corrected Claim When:

- You received a full or partial payment on a claim, but you identified that information must be corrected (some examples: billed wrong # of units, missing claim line, updates to charge amounts, adding a modifier).

How do I know when to Resubmit a Claim?

Submit a Corrected Claim after receiving an 835 showing claim was paid or denied.				
	EDI 1500	**Paper 1500**	**EDI UB**	**Paper UB**
Use frequency 7 for replacing a claim	2300, CLM05-3=7	Field 22, 1st character=7	2300, CLM05-3=7	Field 4, 4th character=7
Use Frequency 8 to void or cancel a prior claim	2300, CLM05-3=8	Field 22, 1st character=8	2300, CLM05-3=8	Field 4, 4th character=8
Always Submit the Original Claim Number	2300, REF01= F8 and REF02= the original claim number from the 835	Field 22, characters 2-13	2320, REF01=F8 and REF02= original claim number from the 835	Field 64, characters 1-12.
Submit (or Re-Submit) a Claim after receiving an 835 showing claim was rejected.				
	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.

In addition, adhering to the following claims filing best practices may reduce duplicate service denials and other unexpected processing results.

- Submit all services on the corrected claim that were on the original claim, plus the corrected information. This includes services that may have already been paid on the original claim submission. The corrected claim will replace all of the information on the original claim. As an example, the original claim had two lines, and the correction was to add a third line. Submit all three lines, not just the third line you are attempting to add.
- Do not submit corrected services from multiple claims on one corrected claim.
- Do not submit a corrected claim if additional information is requested, such as medical records, UNLESS a change is made to the original claim submission.

- When changing a member ID number for a processed claim: Submit a voided claim (frequency 8) canceling charges for the original claim AND submit a new claim with the correct member ID number.
- Always provide the appropriate original claim number associated with the corrected claim.
- Apply the appropriate frequency code in the defined location of the 1500/UB claim form.
- Handwriting or stamping the words “corrected, resubmitted, or voided” on the paper claim will cause the claim to be rejected.

Providers using electronic data interchange (EDI) can submit Professional and Institutional corrected claims electronically rather than via paper to the Plan.

Corrected claims are resubmissions of an existing claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes, or billed amounts. It is not a request to review the processing of a claim. The successful submission of a corrected claim will cause the retraction and complete replacement of the original claim.

- For corrected claims submitted electronically, your EDI clearinghouse or vendor needs to:
  - Use claim frequency code “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use claim frequency code “8” to void a prior claim.
  - Include the original claim number in loop 2300, segment REF01=F8, and REF02=the original claim number; no dashes or spaces.
    - Corrected claims for which the original claim number cannot be validated will be rejected.
  - **Do** use the claim frequency codes for claims that were previously processed (approved or denied).
  - **Do not** use “7” frequency code if the corrected claim is for a different member ID or Provider Tax ID.
    - The original claim must be voided using frequency code “8,” and a new claim must be submitted for these situations.
  - **Do not** use these frequency codes for claims that contained errors and were not processed (rejected upfront). Rejected claims should be resubmitted as a new claim.
  - **Do not** submit corrected claims electronically and via paper at the same time.

For more information, contact the EDI Technical Assistance line found in the *Important Contact Numbers* section of this manual.

- You may also open a claims investigation via NaviNet with the claims adjustment inquiry function.
- Send corrected or resubmitted claims on paper to the address found in the *Claim Mailing Addresses* section of this manual.

Claims originally rejected for missing or invalid data elements must be corrected and re-submitted within 180 calendar days from the date of service. Rejected claims are not registered

as received in the claim processing system, therefore a rejected claim should be submitted as a new claim.

Before resubmitting claims, check the status of both your original and corrected claims online at NaviNet. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

Provider NPI number validation is not performed at the clearinghouse. The clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

The Plan's Provider ID is recommended as follows:

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

Electronic Claim Payment Options

The Plans work with ECHO Health, Inc. (ECHO Health), a leading innovator in electronic payment solutions, to offer more electronic payment options to our healthcare providers so that they can select the payment method that best suits their accounts receivable workflow.

Electronic payment options offered are Virtual Credit Card (VCC), Electronic Funds Transfer (EFT), and MedPay (MPX).

Virtual Credit Card (VCC)

Echo Health offers Virtual Credit Cards as an optional payment method. Virtual Credit Cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. Major advantages to VCC are that providers do not have to enroll or fill out multiple forms in order to receive VCC payments, and personal information, like practice bank account information, will never be requested. Providers will also be able to access their payment the day the VCC is received. In the future, Plan providers who are not currently registered to receive payments electronically will receive VCC payments as their default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, with an instruction page for processing and a detailed Explanation of Payment /Remittance Advice (EOP/RA).

Normal transaction fees apply based on your merchant acquirer relationship.

Note: If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health directly at **1-888-492-5579**.

Electronic Funds Transfers (EFT)

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to

download from the ECHO Provider Portal. If you are new to EFT, you will need to enroll with ECHO Health for EFT from the Plan.

Note: Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO".

To sign-up to receive EFT from the Plan visit ECHO EFT/ERA Enrollment. There is no fee for this service.

To sign-up to receive EFT from all of your payers processing payments on the Settlement Advocate platform, visit ECHO EFT/ERA Enrollment**. A fee may be required to receive EFT if you select the all payers option.** If you have questions regarding how to enroll in EFT, reference the EFT Enrollment Guide.

Refer to the C*laims and Billing* webpage located at www.amerihealthcaritasnext.com > Pick Your State > Claims, Billing, and Payment > Enrollment Central- Getting Started.

MedPay (MPX)

Offered in partnership with Deluxe Corporation, this payment option includes the digital presentment of three payment modalities – 1) eCheck; 2) VCC; or 3) EFT/ACH. This option is specifically targeted to providers who have never enrolled for ACH (EFT) and have opted-out of VCC. Providers who do not want to receive MPX should enroll in EFT immediately following opting out of VCC.

Note: If you have enrolled for MPX with another payer, you will continue to receive your payments through your MPX portal.

Paper

To receive paper checks and paper EOPs, you must opt out of the Virtual Card Services by contacting ECHO Health at 1-888-492-5579, after your initial virtual card payment is received.

Electronic Remittance Advice (ERA)

The Plan also offers ERAs (also referred to as an 835 file) through ECHO Health. To receive ERAs from ECHO, you will need to include both the Plan payer ID and the ECHO payer ID **58379**. Contact your practice management/hospital information system for instructions on how to receive ERAs from the Plan. If your practice management/hospital information system is already set up and can accept Eras from the Plan, then it is important to check that the system includes both the Plan Payer ID and the ECHO Health Payer ID **58379**. Refer to the *Electronic Payer Identification Numbers* section of this manual.

If you are not receiving any payer ERAs, please contact your current practice management/ hospital information system vendor to inquire if your software has the ability to process ERAs. Your software vendor is then responsible for contacting ECHO to enroll for ERAs under both the Plan's Payer ID found in the *Electronic Payer Identification Numbers* section of this manual and the ECHO Health Payer ID **58379.**

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, or if you have additional questions regarding VCC, EFT or ERAs contact the **ECHO Health Enrollment team at 1-888-834-3511**.

For more information, visit the C*laims and Billing* webpage located at www.amerihealthcaritasnext.com > Pick Your State > Claims, Billing, and Payment > Receive electronic remittance advice (ERA)/835 transmissions.

Tips for Accurate Diagnosis Coding

How to Minimize Retrospective Chart Review

We must obtain health status documentation from the diagnoses contained in claims data.

Why are retrospective chart reviews necessary?

Although the Plan captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

What is the significance of the ICD-10-CM Diagnosis code?

International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) codes are identified as 3-digit to 7-digit alpha-numeric codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-10-CM Official Guidelines for Coding and Reporting, providers must code all documented conditions that were present at the time of the encounter/visit and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the member?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

Amputation status	Diabetes mellitus	Multiple sclerosis
Bipolar disorder	Dialysis status	Paraplegia
Cerebral vascular disease	Drug/alcohol psychosis	Quadriplegia
COPD	Drug/alcohol dependence	Renal failure
Chronic renal failure	HIV/AIDS	Schizophrenia
Congestive heart failure	Hypertension	Simple chronic bronchitis
CAD	Lung, other severe cancers	Tumors and other cancers
Depression	Metastatic cancer, acute leukemia	(Prostate, breast, etc.)

What are your responsibilities?

Physicians must accurately report the ICD-10-CM diagnosis codes to the highest level of specificity.

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:

- E11.40 Diabetes with neurological manifestations and E08.40 for diabetic polyneuropathy

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation is clear, concise, consistent, complete, and legible.

Physician Documentation Tips

- First list the ICD-10CM code for the diagnosis, condition, problem, or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- Ensure physician signature and credentials are on each date of service documented.
- Update physician super bills annually to reflect updated ICD-10CM coding changes, and the addition of new ICD-10CM codes.

Physician Communication Tips

When used, the SOAP note format can assist both the physician and record reviewer/coder in identifying key documentation elements.

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

Objective: Data obtained from examinations, lab results, vital signs, etc.

***Assessment*:** Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.

Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

Supplemental Information

Ambulance

Ground and Air Ambulance Services are billed on CMS 1500 or 837 Format

When billing for Procedure Codes A0425 – A0429 and A0433 – A0434 for Ambulance Transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code.

- Providers must bill the transport codes with the appropriate destination modifier.
- Mileage must also be billed with the ambulance transport code and be billed with the appropriate transport codes.
- Providers who submit transport codes without a destination modifier will be denied for invalid/missing modifier.
- Providers who bill mileage alone will be denied for invalid/inappropriate billing.
- Mileage when billed will only be paid when billed in conjunction with a PAID transport code.
- A second trip is reimbursed if the recipient is transferred from first hospital to another hospital on same day in order to receive appropriate treatment. Second trip must be billed with a (HH) destination modifier.
- For 837 claims, all ambulance details are required: Ambulance Transport information, Ambulance Certification, and pick-up and drop-off locations.

Procedure Code Modifiers

The following procedure code modifiers are required with all transport procedure codes. The first place alpha code represents the origin and the second place alpha code represents the client's destination. Codes may be used in any combination unless otherwise noted.

D - Diagnostic or therapeutic site (other than physician's office or hospital)

E - Residential, domiciliary, or custodial facility (other than skilled nursing facility)

G - Hospital-based dialysis facility (hospital or hospital-related)

H - Hospital

I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport

J - Non hospital-based dialysis facility

N - Skilled nursing facility

P - Physician's office (includes HMO non-hospital facility, clinic, etc.)

R - Residence

S - Scene of accident or acute event

X - (DESTINATION CODE ONLY) Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

Anesthesia

Procedure codes in the Anesthesia section of the Current Procedural Terminology manual are to be used to bill for surgical anesthesia procedures.

- Anesthesia claims must be submitted using anesthesia (ASA) procedure codes only (base plus time units).
- All services must be billed in minutes.
- 15-minute time increments will be used to determine payment.

Audiology

Audiology services must be billed on a CMS 1500 claim form or via 837P.

Balance or Surprise Billing

Members are protected from balance billing for:

Emergency services

If a Member has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most the provider or facility may bill the Member is the Members plan's in-network cost-sharing amount (such as copayments and coinsurance). A Member can't be balance billed for these emergency services. This includes services the Member may get during post-stabilization services unless the attending physician states that the patient can safely travel to an in-network facility within reasonable distance or the member gives written consent and gives up their protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a Member gets services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill the Member is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers can't balance bill the Member and may not ask the Member to give up their protections not to be balance billed.

Out-of-network providers

Out-of-network providers must seek prior authorization for non-emergency services and in limited circumstances may be approved to provide care for a member if there is no in-network option for the member to obtain that care. If the out-of-network provider is approved for service, that provider may balance bill for amounts above what the plan will pay. If the out-of-network provider does not seek prior authorization or is not approved, the member will be responsible for the entire charge. It is the out-of-network provider's responsibility to advise the Member and to obtain the Members acknowledgment in writing if the provider does not receive authorization to provide the care so that the Member understands that they are liable for costs.

Billing Multiple Services

The Plan requires that professional claims be billed on one CMS-1500 claim form or electronic 837P transaction when two or more procedures or services were performed for the same patient, by the same performing Provider, and on the same date of service. When services rendered on the same date by the same Provider are billed on two claims, it is defined as "split-billing."

The only instances when split-billing is acceptable to the Plan are when we specifically require services to be billed on separate claims based on a Plan policy (e.g., assistant or co-surgery claims). Some examples of disallowed split-billing include:

- Two or more procedures or services performed by the same Provider, on the same date of service, on the same patient, and submitted on more than one claim form
- Services considered included in the primary services and procedures as part of the expected services for the codes are billed on separate claim forms

Providers must bill on one claim form for all services performed on the same day, for the same patient, unless there is a Plan policy that supports split-billing for the services or procedures performed. Failure to do so prohibits the application of all necessary edits and/or adjudication logic when processing the claim. As a result, claims may be under- or overpaid and Member liability may be under- or over stated.

If a service for which there is no policy to support split billing is inadvertently omitted from a previously submitted claim, the original claim should be corrected.

Note: Do not submit a separate claim for the omitted services, as that will create a split-billed claim and all individually submitted claims will be adjusted to deny.

Chemotherapy

- Services may be billed electronically via 837 electronic format or via paper on a CMS 1500 or UB-04.
- Providers are to use the appropriate chemotherapy administration procedure code in addition to the "J-code" for the chemotherapeutic agent.
- If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M procedure code may also be reported.

Chiropractic Care

- Claims for chiropractic services are billed on a CMS 1500 or via 837 electronic format.
- First visit does not require a referral or prior authorization. Subsequent visits require prior authorization.
- Must bill appropriate CPT code and modifiers.
- Claims submitted with CPT codes 98940, 98941, 98942, and 98943 must be billed with the required modifier for active treatment in an office setting — Modifier: AT (Active Treatment).

All Chiropractic claims submitted without the required modifier will be denied.

Dialysis

- Reimbursement for dialysis services must be billed using the UB-04 claim form or via 837I electronic format.
- The Plan will automatically adjudicate claims for payment for cumulative monthly amounts of erythropoietin equal to or less than 50,000 units. Dialysis centers and/or physicians will be required to submit documentation to the Plan Specialty Drug Program to establish the medical necessity of cumulative monthly doses of erythropoietin greater than 50,000 units. With the exception of facilities contracted at a case rate for Epogen, units over these amounts require prior authorization and will be denied if they are billed without an authorization. Once a specific dose is authorized, it will be approved for up to three months.
- Epogen must be reported with revenue code 634 and revenue code 635.

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form.
- An "RR" modifier is required for all rentals.
- Repair codes on the DME Fee Schedule require the submission of procedure code K0739.
- Program Exceptions – Codes K0868 through K0891 will be reviewed on a case by case basis.
- Benefit Exceptions – Items/services not listed on the Plan's DME fee schedule will be reviewed on an individual basis based on coverage, benefit guidelines, and medical necessity.
- Miscellaneous codes will not be used if an appropriate code is on the Plan's first DME fee schedule.

Family Planning

- Members are covered for Family Planning Services without a referral or Prior Authorization from the Plan. Members may self-refer for routine Family Planning Services and may go to any physician or clinic, including physicians and clinics not in the Plan's Network. Members who have questions or need help locating a Family Planning Services provider can be referred to Member Services at Home Health Care (HHC)
- Provider must bill on CMS 1500, UB04, or 837 electronic format (whichever format is designated in their Plan contract).
- When billing on a UB04, bill the appropriate revenue code for the homecare service.
- Providers must bill the appropriate modifier in the first position when more than one modifier is billed.
- Refer to NDC instructions in the manual.

Infusion Therapy

- Drugs administered by physician or outpatient hospital require prior authorization.
- Drugs require the provider to also bill the NDC and NDC-related information.
- Failure to bill the NDC required information will result in denial.

Injectable Drugs

All drugs billed are required to be submitted with NDC information and may be submitted via CMS-1500 or 837 electronic format. Refer to Special Instructions and Examples for CMS 1500, UB-04 and EDI Claim Submissions

The NDC number and a valid HCPCS code for drug products are required on both the 837 electronic format and the CMS-1500 for reimbursable medications. For 837I claims, submit only one NDC per line; the clearinghouse only considers the first NDC on a claim line.

Maternity

Prenatal care providers are encouraged to complete the Plan pregnancy assessment/risk form to assess risk for each expectant mother.

The form is available in the Forms and Documents webpage located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Forms and Documents > Maternity.

The completed form should be faxed to maternity care management at the number at the bottom of the form within seven calendar days of the date of the prenatal visit as indicated on the form. Upon submission of the form, you will receive an authorization number for your obstetrics visits for your patient.

Prenatal visits with a pregnancy diagnosis must be billed separately from the actual delivery.

Postpartum visits must be billed with a pregnancy diagnosis and performed within 21 to 56 days after the delivery.

Multiple Surgical Reduction Payment Policy

The Plans adhere to the following payment procedure:

- When two or more surgical inpatient or outpatient procedures are performed by the same practitioner on the same day, the practitioner will be reimbursed at 100% of the Medicare allowable rate for the highest allowable payment for one procedure and will be reimbursed 50% of the allowable rate for all subsequent procedures.
- When two or more surgical procedures are performed and anesthesia is provided by the same anesthesiologist during the same period of hospitalization, the anesthesiologist will be reimbursed at 100% for the highest allowable payment for one procedure and 50% of the allowable amount for all subsequent procedures, when billed with the appropriate modifiers.
- When two or more surgical procedures are performed during the same surgical event, and anesthesia is provided by the same anesthesiologist, the anesthesiologist should bill for the highest billable anesthesia procedure code. All anesthesia time must be allotted to that single anesthesia procedure code. No payment will be made for additional anesthesia procedures provided during that surgical event, with the exception of codes 01967, 01968, and 01969.

Newborn, adopted, and foster child claims

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. Separate claims should be submitted for the mother and their newborn. Providers should submit the newborn claims under the mother's ID with the newborn's date of birth. Provided the date of service falls within the paid through date or 30-day grace period, the plan will process claims for the first 30 days of the newborn's life. Coverage includes services due to injury or sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and routine care furnished any infant from the moment of birth. If the subscriber enrolls the newborn during the 30-day window, the newborn will be added using the standard enrollment process.

For more information on the special enrollment circumstances, including a newly adopted child or foster child please refer to the member's Evidence of Coverage.

The Evidence of Coverage can be located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Out-of-Network Providers

The Plan uses network providers to provide covered services to Members. This means that we will not pay for services Members might receive from out-of-network providers unless the Member has an emergency medical condition or we authorize services from an out-of-network provider because the medically necessary services are not available from a network provider.

Out-of-network providers are required to submit emergency or pre-authorized claims within 180 days from the date of service. Providers are required to give notice of any claim for services rendered by an out-of-network provider. No payment will be made for any claims filed by a Member for services rendered by an out-of-network provider unless written notice of such a claim is provided to the Plan within 180 days of the date of service, unless it is for emergency care or transportation.

To give notice of a claim, please call the Plan at the phone number listed on the Member's ID card to obtain a claim form. The Member must sign the claim form before the Plan will issue payment to reimburse the Member for covered services received under this policy if the member is paying out of pocket. When the member completes the form, it should be submitted to the Plan with an itemized bill and proof of payment.

The *Member Reimbursement Medical Claim Form* can be found at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Member Reimbursement Medical Claim Form.

Physical/Occupational and Speech Therapies

Medically necessary services for habilitation and rehabilitation, including speech therapy, occupational therapy, and physical therapy must be ordered by a physician and delivered by appropriately licensed medical personnel. Services must be provided to help a person keep, learn, or improve skills and functioning of daily living. We will determine if the service is covered by reviewing both the skilled nature of the service and the need for physician management. These services may be provided in an inpatient or outpatient setting. Therapy services may be billed on a UB-04 or CMS 1500 claim form or via 837 electronic format.

In order to debit the services properly, providers are required to include Modifier 96 or 97 with claim submission.

- Modifier 96: Habilitative Services: Help an individual keep, learn, or improve skills and functioning for daily living.
- Modifier 97: Rehabilitative Services: Help individual keep, get back, or improve skills and functioning of daily living that have been lost or impaired because the individual was sick, hurt, or disabled.
- Modifier GP: Services delivered under an outpatient physical therapy plan of care
- Modifier GO: Services delivered under an outpatient occupational therapy plan of care
- Modifier GN: Services delivered under an outpatient speech language pathology plan of care

Sterilization

Sterilization is defined as any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilization for members under age 21 is not covered. Hysterectomy for sterilization is also not covered. A member seeking sterilization must voluntarily give informed consent.

Termination of Pregnancy

First and second trimester terminations of pregnancy require prior authorization and are covered in the following two circumstances:

- The member's life is endangered if she were to carry the pregnancy to term; or
- The pregnancy is the result of an act of rape or incest.

Ensure that the physician certification and all complete medical records are included when submitting the claim for reimbursement. All claims, certifications, and medical records will be retained by the Plan.

For more information, please refer to the members Evidence of Coverage located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Provider Preventable Conditions and Critical Incidents

All critical incidents require notification to the Plan immediately or as soon as reasonably possible following the incident. A critical incident includes but is not limited to the following incidents:

- Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician
- Suspected physical, mental, or sexual mistreatment; abuse; and/or neglect of a member
- Suspected theft or financial exploitation of a member
- Severe injury sustained by a member
- Medication error involving a member
- Inappropriate/unprofessional conduct by a provider involving a member

In addition to the list above, critical incidents include Sentinel and Never events as defined below:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events. Examples of a

sentinel event include:
    - Maternal death after delivery
    - Suicide while inpatient

- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above. Examples of Never Events include:
    - Surgery performed on the wrong patient
    - Surgery on the wrong body part
    - Unintended retention of a foreign object after surgery

See CMS.gov for a complete list.

Provider Preventable Conditions Reimbursement

The Plans comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPCs). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions.

Health Care Acquired Conditions

The category of Health Care Acquired Conditions (HCAC) applies to the plans inpatient hospital settings only. Under this category, the Plans do not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcers (decubitus ulcers)
- Vascular catheter-associated infection
- Mediastinitis after coronary artery bypass graft (CABG)
- Hospital-acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes)
- Manifestations of poor glycemic control
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric and obstetric populations

Other Provider Preventable Conditions

- Post-operative death in a normal healthy patient
- Death/disability associated with use of contaminated drugs, devices, or biologics
- Death/disability associated with use of device, other
- Death/disability associated to medication error
- Maternal death/disability with low-risk delivery

- Death/disability associated with hypoglycemia
- Death/disability associated with hyperbilirubinemia in neonates
- Death/disability due to wrong oxygen or gas

Never events:

- Surgery on a wrong body part or site
- Wrong surgery on a patient
- Surgery on the wrong patient

The Plans monitor the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies, and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan.

The Plan's goals are to:

- Improve patient care, treatment, and services, and prevent unusual occurrences.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.

Reporting Critical Incidents

Providers are expected to report critical incidents, as described above, to the Plan in real-time. The Plan recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the member prior to reporting. All critical incidents must be reported to the Plan within 24 hours of occurrence through the identified critical incident reporting process noted in the Special Instructions and Examples for CMS 1500, UB-04 and EDI Claim Submissions section of this manual.

The Plans will not take punitive action or retaliate against any person for reporting the occurrence of critical incidents. The practitioners involved will be offered the opportunity to present factors leading to the event and to respond to any questions arising from the review of the critical incident.

Once a Plan staff member identifies or is notified of a critical incident, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Quality Management department is notified of the event via an incident report, telephone, or email as soon as reasonably possible after identification of the occurrence.
2. The Quality Management Director will collaborate with the Market Chief Medical Officer and investigate, as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality Management department leads the investigation, analysis, and reporting of

all identified unusual occurrences.

4. All critical incidents require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance.
5. As appropriate, issues are identified for correction, and corrective action plans are developed by the provider to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The corrective action plan by the provider will address responsibility for implementation, oversight, timelines, and strategies for measuring the effectiveness of the actions.
6. As appropriate, and as required by applicable law, the plans will notify state and federal agencies of critical incidents.
7. As appropriate, information from the investigation of critical incidents will be provided to the Credentialing Committee to support the re-credentialing process.

Reporting Provider Preventable Conditions

To report suspected abuse or neglect, please contact the Plan's Provider Services number indicated in the *Important Contact Numbers* section of this manual.

Payment Adjustments

Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the Medical Necessity of the services provided. Additionally, payment may also be adjusted if the Member's eligibility changes between the times the authorization was issued and the service was provided.

Prospective Claims Editing Policy

The Plans' claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Retroactive Denials

A retroactive denial is the reversal of a previously paid claim, pursuant to which the member or other third party then becomes responsible for payment.

Claims may be denied retroactively even after the member has obtained services from the provider based on retroactive changes to eligibility, reasons for which may include, but are not limited to failure to pay premiums and instructions from the Health Insurance Marketplace.

Retrospective Reviews of Claims

The Plan may conduct retrospective reviews of claims for services that did not receive prior authorization. The Plan will complete these retrospective reviews within 90 days of the date the claim is paid. The Plan may recover payments from providers for reimbursed services determined not to be Medically Necessary.

Most Common Claims Errors for CMS-1500

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	**"Member name is missing or illegible."** (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"**Member date of birth (DOB) is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"**Member's sex is required.**" (If no box is checked, the claim will be rejected.)
4	Insured's Name	"**Insured's name missing or illegible.**" (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address (number, street, city, state, zip+4) phone	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"**Patient relationship to insured is required.**" (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address (number, street, city, state, zip+4) phone	**"Insured's address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	**"Diagnosis code is missing or illegible."** (The claim will be rejected.)
24	Supplemental Information	"**National Drug Code (NDC) data is missing/incomplete/invalid.**" (The claim will be rejected if

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
		NDC data is missing, incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	**"Date of service (DOS) is missing or illegible."** (The claim will be rejected if both the" From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	**"Place of service is missing or illegible."** (Claim will be rejected.)
24D	Procedure, Services or Supplies	**"Procedure code is missing or illegible."** (Claim will be rejected.)
24E	Diagnosis Pointer	"**Diagnosis (DX) pointer is required on line ___" [lines 1-6].** (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"**Line item charge amount is missing on line ___" [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"**Days/units are required on line ___" [lines 1-6].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	**"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible."** (If NPI is missing or illegible, claim will be rejected.)
26	Patient Account/Control Number	**"Patient Account/Control number is missing or illegible"** (If missing or illegible, claim will be rejected.)
27	Assignment Number	"**Assignment acceptance must be indicated on the claim.**" (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"**Total charge amount is required.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
31	Signature of physician or supplier including degrees or credentials	**"Provider name is missing or illegible."** (If the provider's name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	"**Billing provider name and/or address is missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	**"Field 33 of the CMS1500 claim form requires the provider's physical service address including the full 9 character ZIP code + 4."** (If a P.O. Box is present, the claim will be rejected.)

Most Common Claims Errors for UB-04

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
1	Billing Provider Name, Address and Telephone Number	"**Billing provider name and/or address missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
1	Billing Provider Name, Address and Telephone Number	"**Field 1 of the UB04 claim form requires the provider's physical service address."** (If a P.O. Box is present, the claim will be rejected.)
3a	Patient Account/ Control Number	"**Patient account/control number is missing or illegible.**" (If the number is missing or illegible, the claim will be rejected.)
4	Type of Bill	**"If claim is a resubmission, include frequency code as the last digit. Include original claim number in Field 64."** (If frequency code is missing or invalid, the claim will be rejected.)
8b	Patient Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
9a-e	Patient Address	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
10	Patient Birth Date	"**Member DOB is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)
11	Patient Sex	"**Member's sex is required**" (If missing, the claim will be rejected.)
12	Admission Date	"**Admission Date is missing or illegible.**" (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, do not reject claim. If it is IP and a valid date is not billed, the claim will be rejected.)
12	Admission Date	"**Based on the date the claim was received, the admission date is a future date.**" (Use bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject claim. If it is IP and a future date is billed, reject the claim.)
13	Admission Hour	"**Admission hour is required.**" (Use bill type table to identify if it is an IP or OP claim. If it is OP, do not reject the claim. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the claim will be rejected.)
14	Admission Type	"**Admission type is required.**" (If a numeric value is not present, claim will be rejected.)
15	Point of Origin for Admission or Visit	"**Point of Origin for admission or visit is missing.**" (If claim has any bill type except 14x and the field is blank, claim will be rejected.)
16	Discharge Hour	"**Discharge hour is required.**" (Use type if bill table to determine if it is an IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, claim will be rejected.)
17	Patient Discharge Status	"**Patient discharge status is required.**" (If left blank, claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
42	Revenue Code	"**Revenue code is missing or illegible.**" (If the revenue code is missing or illegible, the claim will be rejected.)
45	Service Date	"**DOS is missing or illegible.**" (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)
45	Creation Date	"**Creation date is missing or illegible.**" (If the creation date is missing or illegible, the claim will be rejected.)
46	Service Days/Units	"**Days/units are required on line ___." [lines 1-22].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
47	Line Item Charges	"**Line item charge amount is missing on line___." [lines 1-22].** (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	Total Charges	"**Total charge amount is missing.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	Payer	"**Payer name is required.**" (If left blank, the claim will be rejected.)
52	Release of Information	**"Valid release of information certification indicator is required.**" (If blank or invalid, the claim will be rejected.)
53	Assignment of Benefits	**"Valid assignment of benefits certification indicator is required.**" (If blank or invalid, the claim will be rejected.)
58	Insured's Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
59	Patient's Relationship	**"Valid patient's relationship to insured is required.**" (If blank or invalid, the claim will be rejected.)
64	Document Control Number (DCN)	If claim is a resubmission, include the original claim number. Note: include frequency code in

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
		Field 4. (If original claim number is missing or invalid, the claim will be rejected.)
67A-Q	Other Diagnosis Codes and Present on Admission Indicator	"**Diagnosis codes are missing or illegible.**" (If diagnosis codes are missing or illegible, the claim will be rejected.)
69	Admitting Diagnosis Code	"**Admitting diagnosis code is missing or illegible.**" (If it is an IP claim and field is blank or illegible, the claim will be rejected.)
70	Patient's Reason for Visit	"**Patient's reason for visit is missing.**" (If the claim is OP and field is blank, the claim will be rejected.)
74	Other/Procedure Date	"**Based on the date the claim was received, procedure date is a future date.**" (Use the bill type table to identify if it is an IP or an OP claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)
74	Other/Procedure Date	"**Procedure date is missing or illegible.**" (Use bill type table to identify if it is an IP or an OP claim. If OP, do not reject the claim. If IP and a valid date is not billed, reject the claim.)
76	Attending Provider Identifiers: Name and NPI	"**Attending physician name and/or number is missing.**" (If attending physician name or NPI number are missing, the claim will be rejected.)
76	Attending Provider Qualifier	"**Attending provider qualifier is missing/ invalid.**" (The claim will be rejected if the "Other provider ID" is present and either: 1) The 'Qualifier' box is blank, or 2) A qualifier other than 0B/1G/G2 is present.
76	Attending Provider Other ID#	**"Attending Provider NPI is missing."**(The claim will be rejected if qualifier is present and Other ID box is blank.)