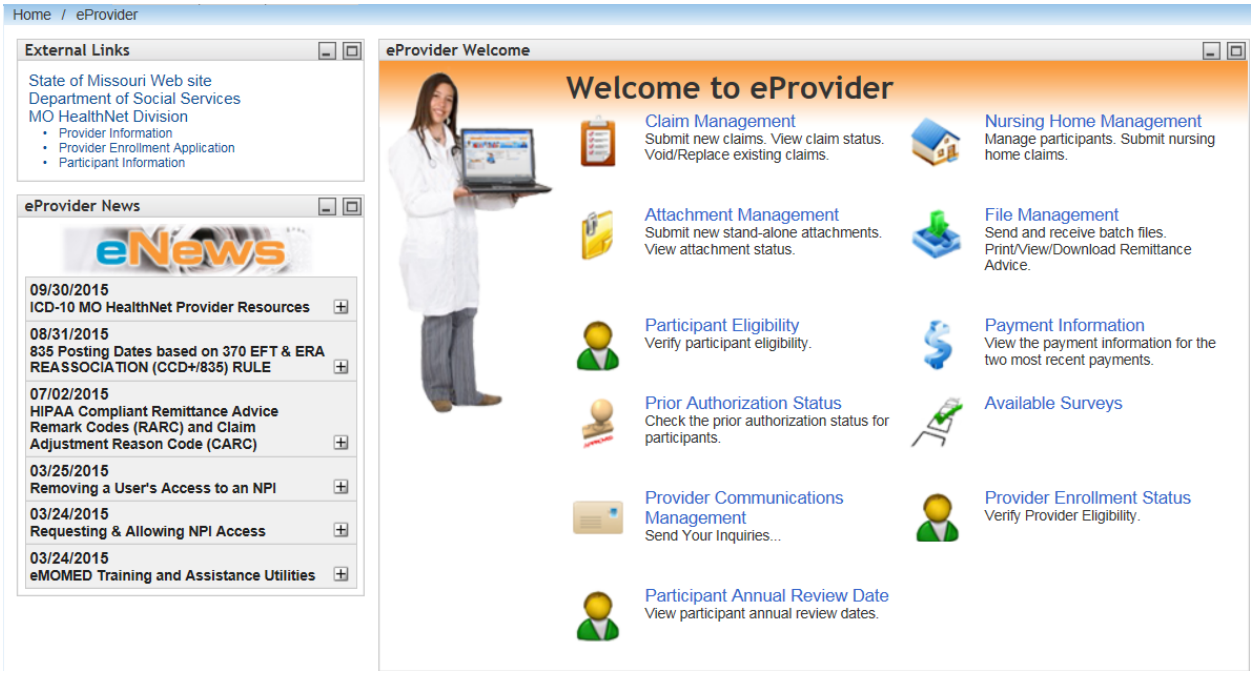
Section 2
Behavioral Health
Electronic CMS-1500 Claim Form Filing Instructions
www.emomed.com.

Apply online via the Application for MO HealthNet Internet Access Account link, to utilize the internet for eligibility verification, electronic claim submissions, and RA retrieval. Each user is required to complete this online application to obtain a user ID and password. The application process only takes a few minutes and provides a real-time confirmation response, user ID, and password. Once the user ID and password has been obtained, the user can begin accessing the www.emomed.com website.

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

Any questions regarding the completion of the on-line Internet application, contact the MHD Help Desk at (573) 635-3559.

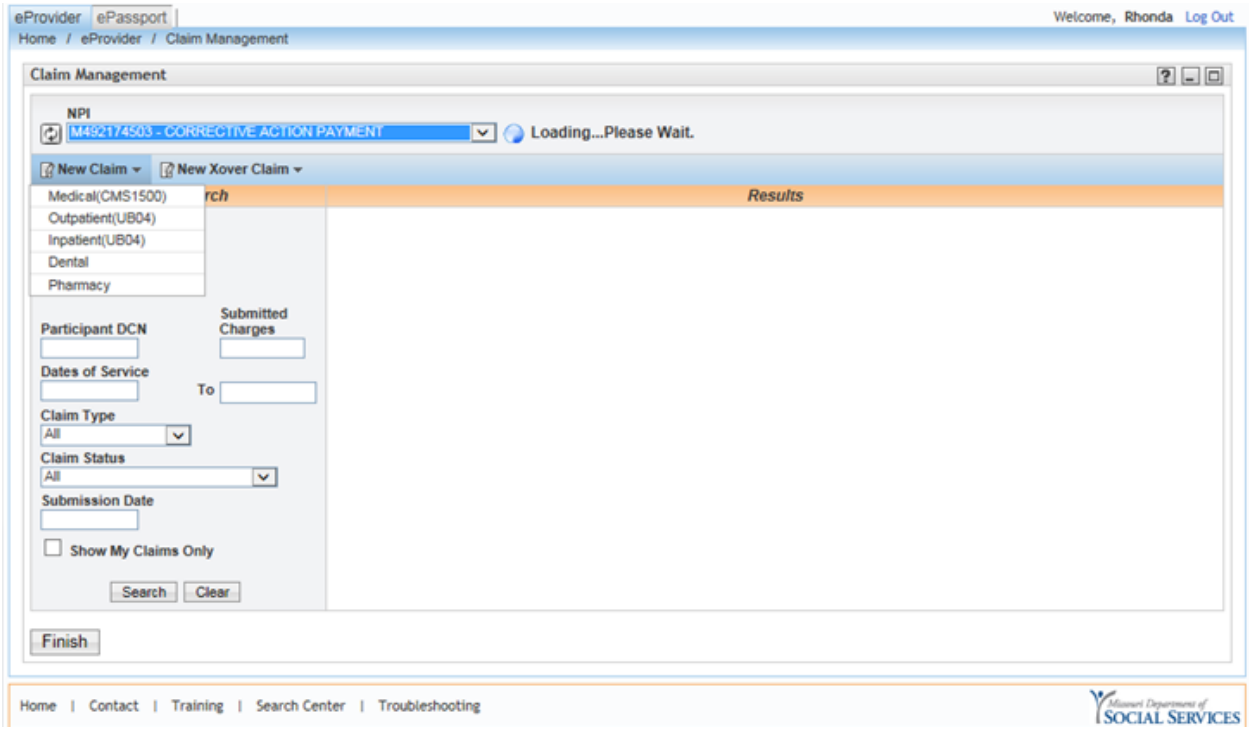


Welcome to eProvider

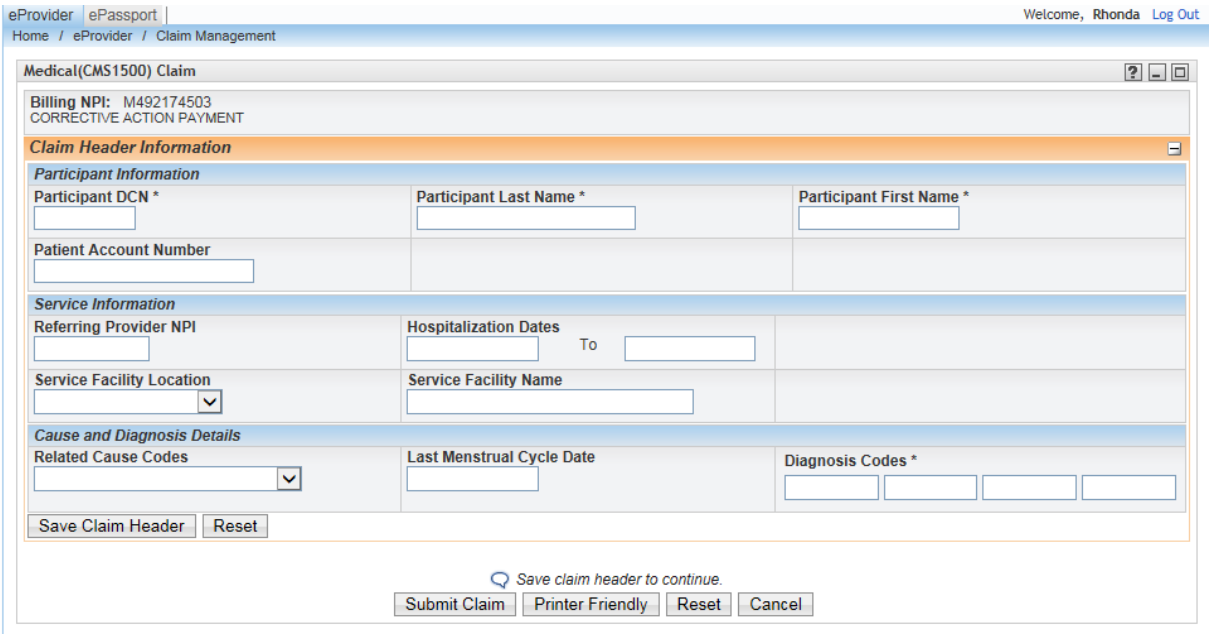
Select Claims Management

Select New Claim

Select Medical (CMS 1500) form from the drop down list to begin a new claim.

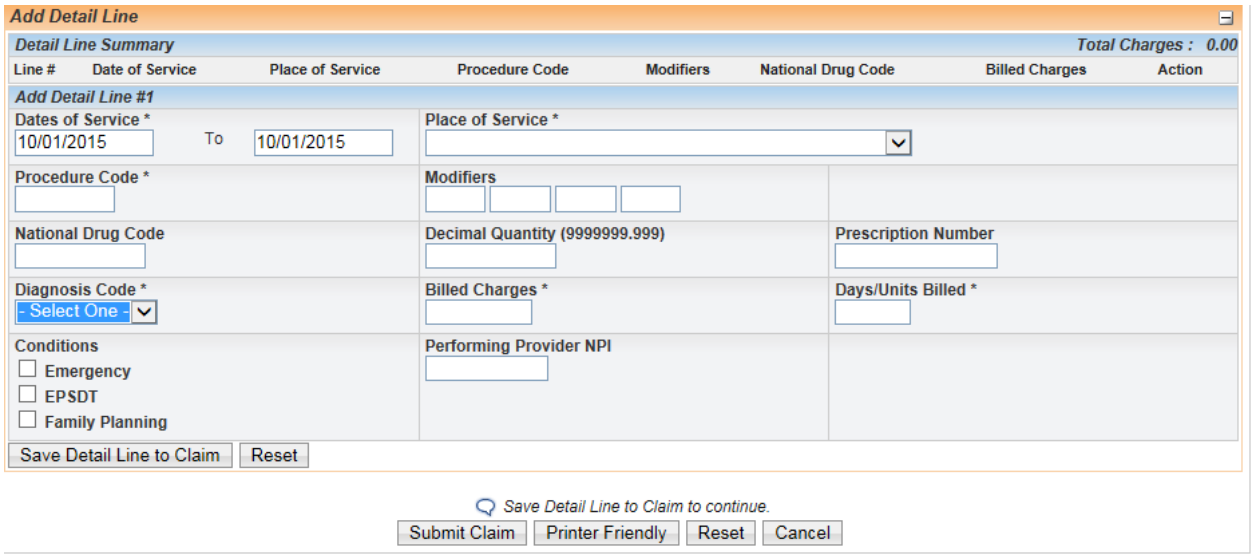


NOTE: An asterisk (*) beside field numbers indicate required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.



Claim Header Information	**Instructions for completion**
Participant's DCN*	Enter the participant's eight-digit MO HealthNet Departmental Client Number (DCN) as shown on the participant's ID card.
Participant's Last Name*	Enter last name as it appears on the participant's ID card.
Participant's First Name*	Enter first name as it appears on the participant's ID card.
Patient Account Number	Enter the participant's account number used by the billing provider's office.
Service Information	**Instructions for completion**
Referring Provider NPI	Enter the referring physician's MO HealthNet National Provider Identifier (NPI) and Taxonomy code (if applicable). This field is required for independent laboratories and independent radiology groups and physicians

	with a specialty of “30” (radiology/radiation therapy).
Hospitalization Dates	If services are provided in an inpatient hospital setting, enter the hospital From and To date of the hospitalization. Otherwise leave blank.
Service Facility Location	If billing for laboratory charges, choose the appropriate value. The referring physician may not bill for lab work that was referred out. If services were provided in the physician’s office/clinic please leave blank. The valid values are: 77- Service Location
Service Facility Name	If services were rendered in a facility other than the home or office, enter the name of the facility. Otherwise, leave blank.
Cause and Diagnosis Details	**Instructions for completion**
Related Cause Codes	If services on the claim are related to participant’s employment, auto accident or other accident, chose the appropriate value. If the services are not related to an accident, leave blank. The valid values are: AA- Auto accident AB- Abuse AP- Another Party Responsible EM- Employment OA- Other accident
Last Menstrual Cycle Date	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
Diagnosis Codes	Enter the complete diagnosis code(s) without decimals. The primary diagnosis in Field 1, the secondary diagnosis in Field 2, etc.
Save Claim Header	Select Save Claim Header tab to save the header information.
Reset / Cancel (claim header)	Select Reset or Cancel tab to clear all the data from the header.



Add Detail Line Summary	**Instructions for completion**
Date(s) of Service*	Enter the From Date / To Date of Service.
Place of Service*	Enter the appropriate place of service (POS) code for the services billed.

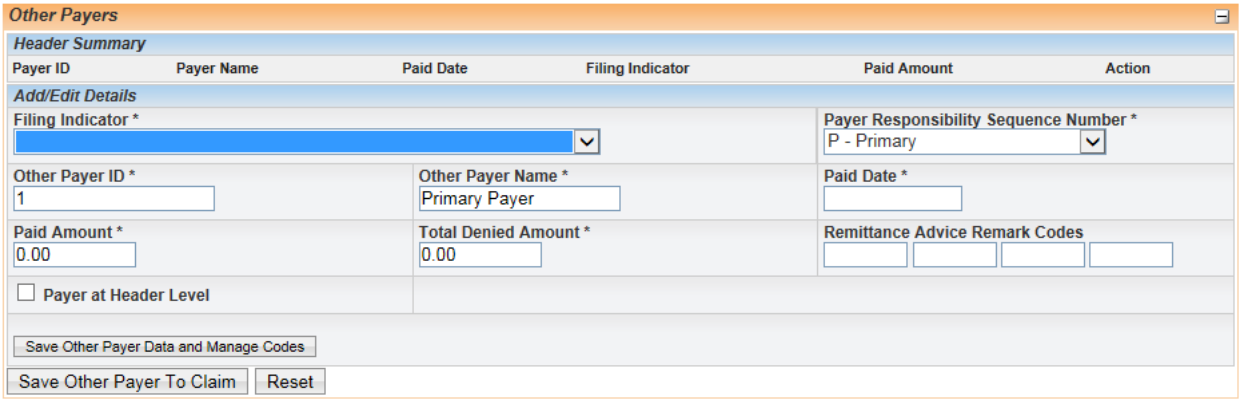
Note: Reference **program specific provider manuals** for appropriate POS codes.

The valid POS codes are:
03 Public Schools
04 Homeless Shelters
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room Hospital
32 Nursing Facility
33 Custodial Care Facility
50 Federally Qualified Health Center (FQHC)
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
55 Residential Substance Abuse Trmt. Facility
56 Psychiatric Residential Treatment Center
57 Non-Residential Substance Abuse Trmt.
61 Comprehensive Inpatient Rehab Facility
62 Comprehensive Outpatient Rehab Facility
72 Rural Health Clinic (RHC)
97 Private/Parochial Schools
98 Schools
99 Other Unlisted Facility

Procedure Code*	Enter the appropriate procedure code.
Modifiers**	Enter the applicable modifier, if any, corresponding to the service rendered.
National Drug Code	Procedure Code (Current Procedural Terminology (CPT) / Health Care Procedure Coding System (HCPCS)) entered represents a drug, enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. Enter the 5-4-2 format, if the drug code on the package is not in 5-4-2 format, enter zeros in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.
Decimal Quantity	Procedure Code (CPT/HCPCS) entered represents a drug, enter the decimal quantity dispensed or used in administration, as follows: Number of tablets dispensed, Number of grams for ointments or powders. Number of cc's (ml's) administered for solution products (ampule, I.V. bag, bottle, syringe, vial). Number of vials used containing powder for reconstitution. Immunizations and vaccines need to be billed by the ml/cc not by the dosed administered (ampule, I.V. bag, bottle, syringe, vial) Number of Kits administered 1 Kit = 1 unit (Implants, Pegasys, Copaxone)
Prescription Number	Procedure Code (CPT/HCPCS) entered represents a drug, enter the number assigned by the pharmacy, outpatient facility or physician's office or enter a sequential identification number in this field. If the billing provider chooses to use the patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service.

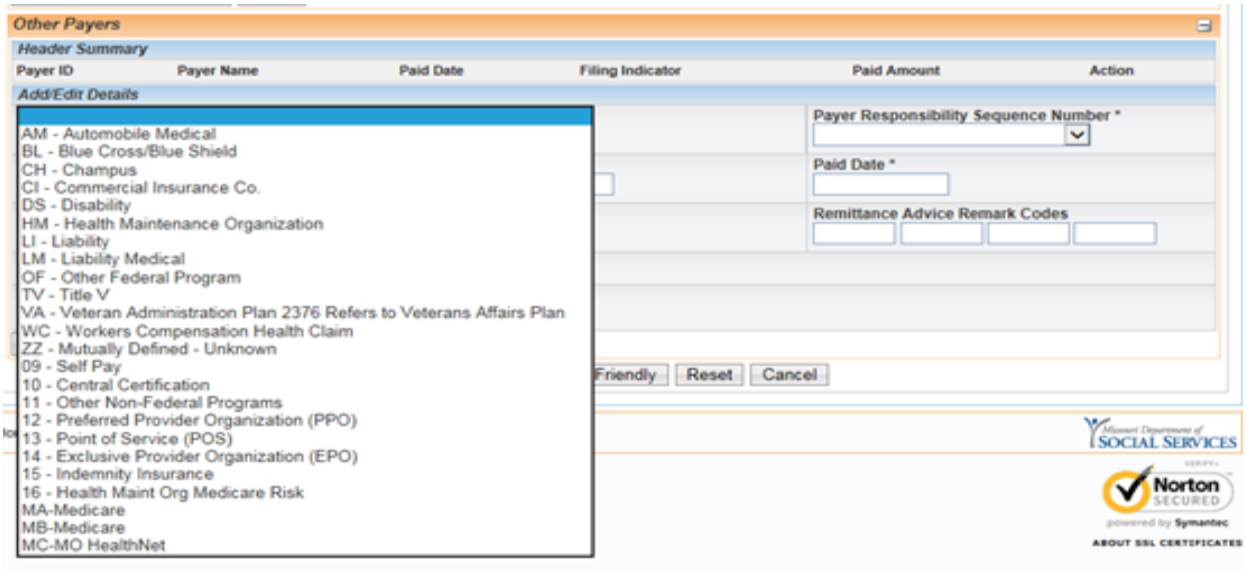
Note: This number is used to sort claims submitted electronically on the remittance advice.

Diagnosis Code*	Select the desired Diagnosis Code.
Billed Charges*	Enter the provider's usual and customary charge per detail line. This should be the total charge if multiple days or units are shown.
Days/Units Billed*	Enter the number of days or units of service provided for detail line.
Conditions	Check the box for service provided involving one or more of the following: Emergency Services; Early and Periodic Screen for Diagnosis and Treatment (EPSDT) of children services; Family Planning services
Performing Provider NPI**	This field is required for a clinic, radiology, teaching institution or **group practice** only. Enter the Missouri MO HealthNet Provider Identifier (NPI)
Taxonomy Code**	Enter the performing Provider taxonomy code, (if applicable) of the physician or other professional who performed the service.
Save Detail Line to Claim	Select Save Detail Line to Claim tab to save the detail line information. This **only saves** the **current detail line**, the claim must still be submitted.
Reset / Cancel (claim detail)	Select Reset or Cancel button to clear the data from the Claim Detail Line section.



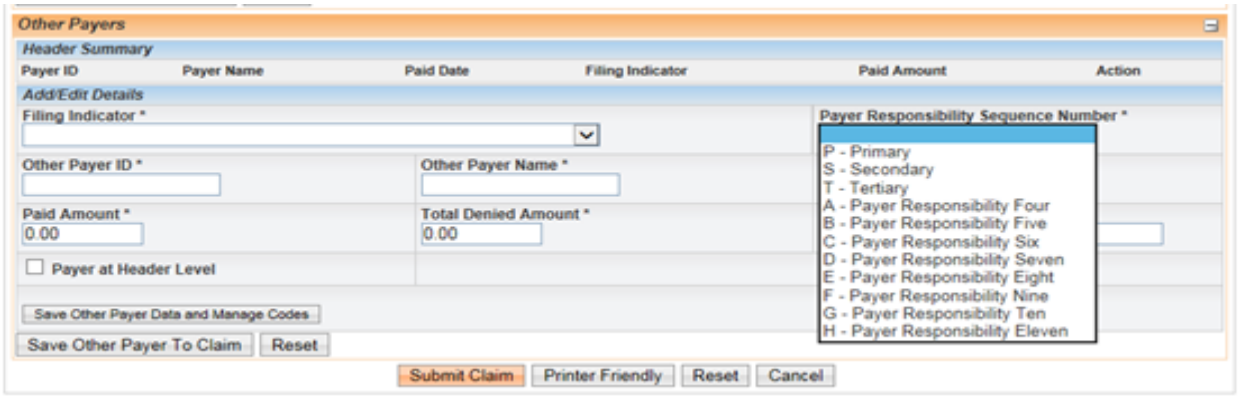
Other Payer Attachment *

Enter the Other Payer (insurance) information reported from the Other Payer Explanation of Benefits (EOB) or the Other Payer (insurance) Remittance Advice



Filing Indicator*

Select the filing indicator that defines the other payer type.



Payer Responsibility Sequence Number *

Indicate which other payer processed the claim. Select primary, secondary, tertiary, etc.

Other Payer ID*

Enter the unique identifier of the other payer as provided on the other payer remittance advice. This field may contain numeric or alpha-numeric data up to 20 characters in length.

Note: If not provided, use sequential numbering starting with one (1) for the first payer, two (2) for the second other payer, and etc.

Note: The payer ID in the header must correspond to the payer ID in the detail. For example, if payer has a payer ID of 1234 on the header, must also have a payer ID of 1234 on the detail.

Other Payer Name*	Enter the name of the Other Payer.
Paid Date*	Enter the date the other payer paid.
Paid Amount*	Enter the amount paid including decimals by the Other Payer.
Total Denied Amount**	Enter the **total** denied amount including decimals processed by the Other Payer.
Remittance Advice Remark Codes	Enter the Health Insurance Portability and Accountability Act (HIPAA) approved X12 remittance remark code reported for this claim on the remittance advice or claim status response received from the other payer.
Payer at Header Level (checkbox)	Check the box if the other payer is at the header level.
Save Other Payer Data and Manage Codes	Select Save Other Payer Data to Claim to save the **Header Summary** information.

Note: The next step is to complete the Group Code, Reason Code, and Adjust Amount for this Payer. The claim must still be submitted.

Associated Line Item (checkboxes)*	Select the appropriate checkboxes to enter the detail lines the other payer codes apply.
Claim Group Code*	Enter the HIPAA- approved X12 adjustment group code assigned by the other payer. If other payer does not use HIPAA- approved

	adjustment group codes, you must determine which approved code would be appropriate to submit.

Note: Each adjustment **group code** should be entered if multiple adjustment group codes are reported on the Explanation of Benefits (EOB) or Remittance Advice (RA).

Note: Other Payer adjustments reported to the claim's **total billed** amount at the **header** level **(one total sum)** must be reported on the Other Payer Header.

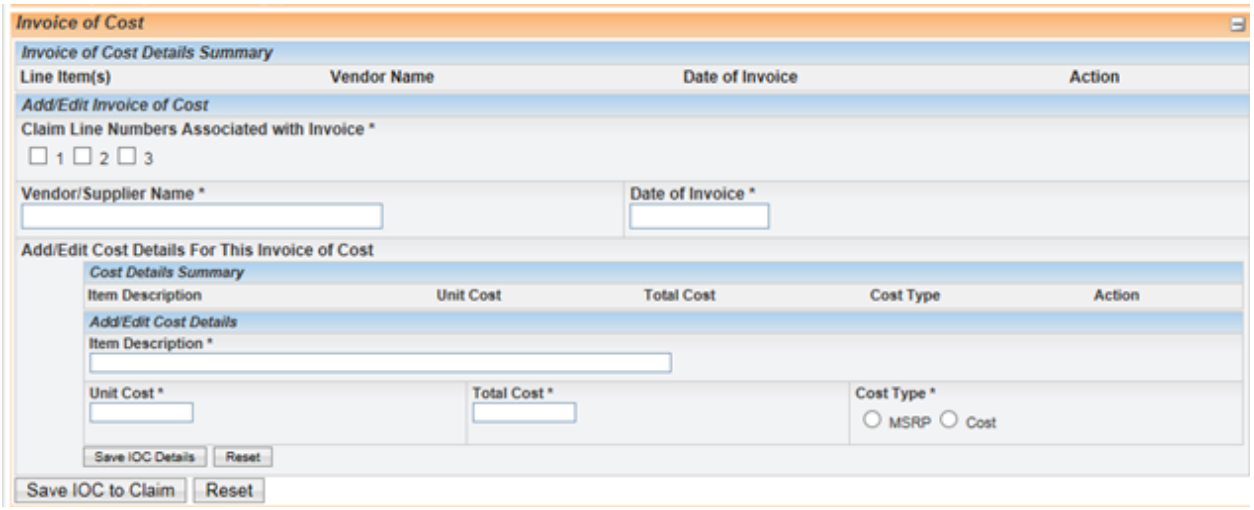
Note: Other Payer adjustments reported to the claim's **detail line** billed amounts must be reported on the **Other Payer Detail**.

Note: If **both** header and detail line level adjustments were made by the other payer, **both** the Other Payer Header and the Other Payer Detail must be completed.

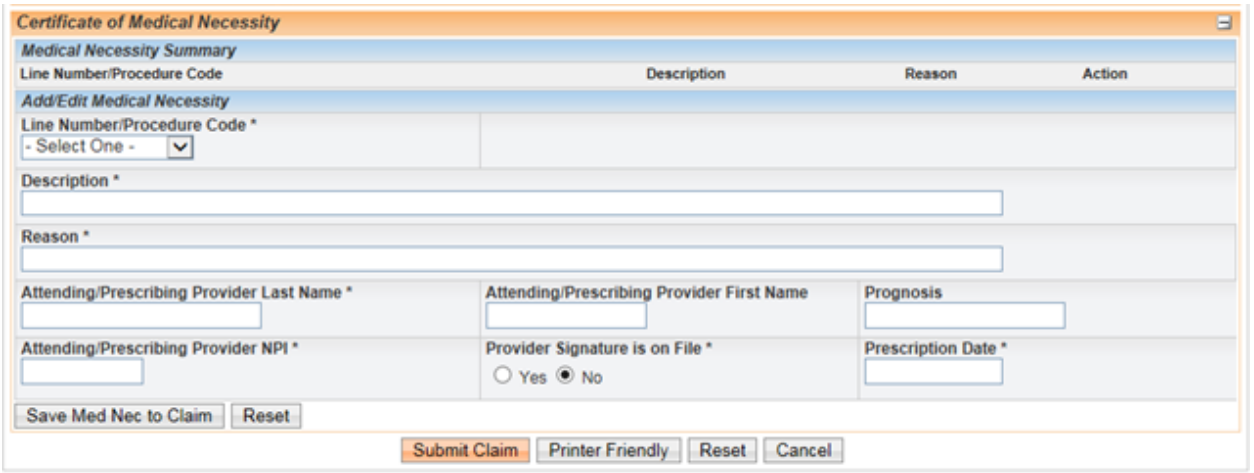
ONLY approved Health Insurance Portability and Accountability Act (HIPAA) X12 codes are acceptable. These codes can also be found in the HIPAA Related Code List under the Quick Links at http://www.dss.mo.gov/MHD.

Claim Adjustment Reason Code*	Other payer paper remittance advices do not show adjustment reason code for the deductible and coinsurance. Enter **"001"** for billing deductible and **"002"** for coinsurance. Part C-NON QMB paper remittance advices do not show adjustment reason code for the copay. Enter **"003"** for billing copay.
Adjustment Amount*	Enter the **Adjustment Amount(s)**, including decimals, assigned on the claim by the other payer. The Adjustment Amount(s) is the amount that was NOT paid by the other payer, thus adjusting the reimbursement or covered amount from the submitted charge.
Save Codes to Other Payer	Select Save Codes to Other Payer to save the Codes to Other Payer information to the claim. Note: The claim must still be submitted.
Save Other Payer to Claim	Select Save Other Payer to Claim to save Other Payer to Claim information to the claim. Note: The claim must still be submitted.

Invoice of Cost Attachment	Complete the Invoice of Cost attachment, If applicable.

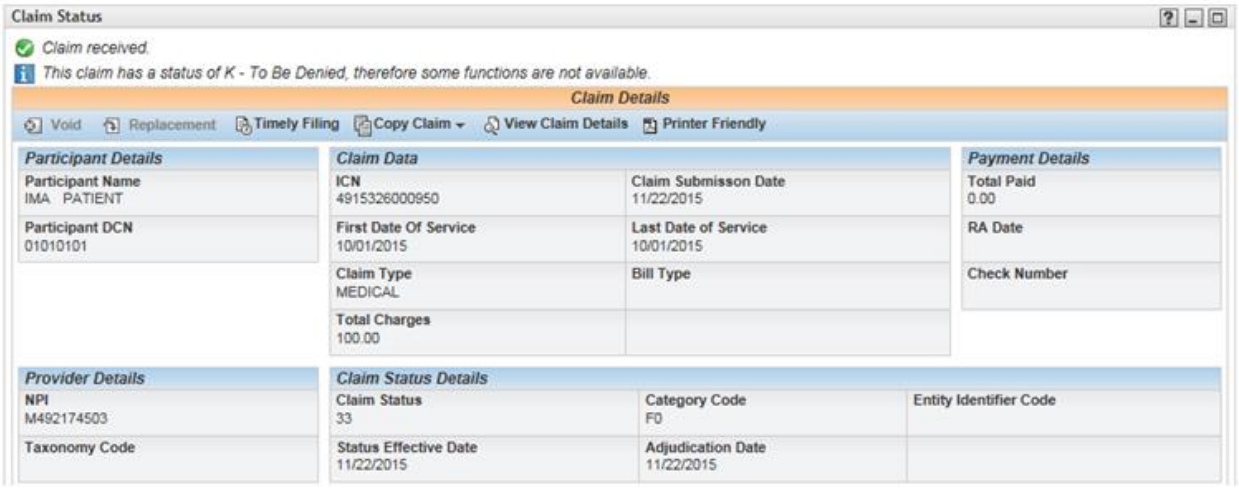


Medical Necessity Attachment	Complete the Certificate of Medical Necessity attachment, if applicable.



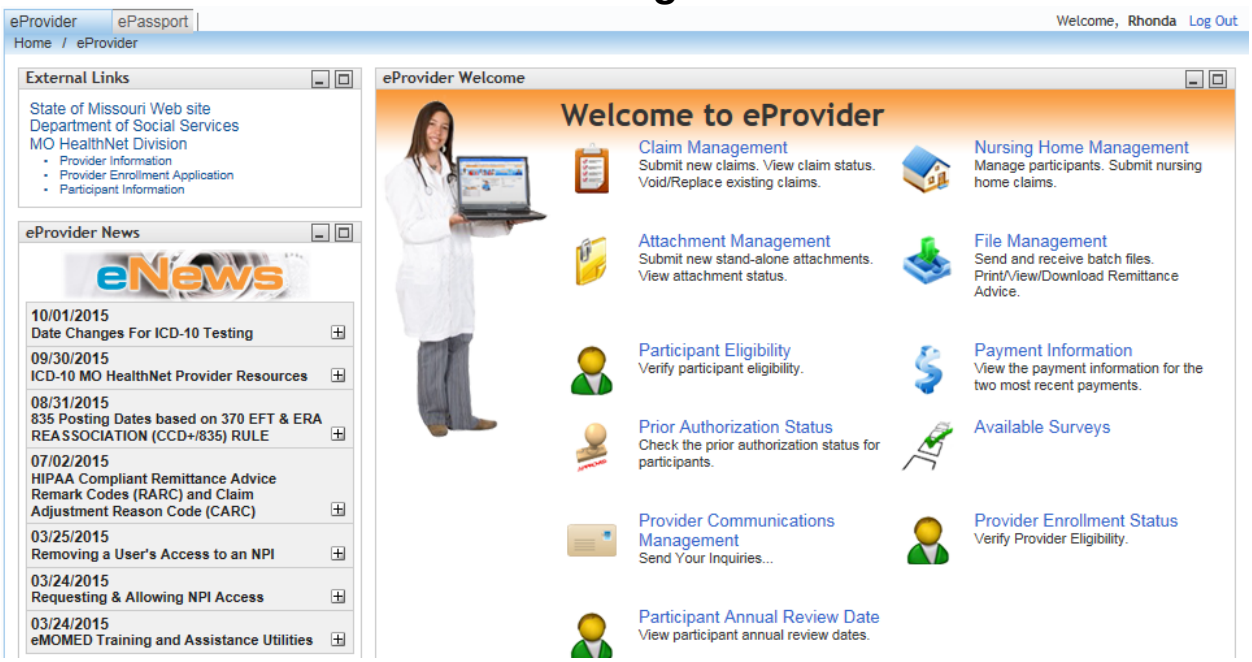
Submit Claim	Select Submit Claim to submit the claim.
Printer Friendly	Select Printer Friendly to open the claim in a printer friendly PDF format.
Reset	Select Reset to discard all of the previously entered medical claim information.

Cancel	Select Cancel to discard all of the previously entered medical claim information.



Claim Status	Processed claim has a status of K - to be **Denied**. Processed claim has a status of I - to be **Paid**. Processed claim has a status of C - **Captured** claim is still processing. (i.e. attachment, authorization, consultant review) This claim should not be resubmitted until it has a status of I or K.
Internal Control Number (ICN) Number	Each processed claim is assigned an ICN.

Electronic CMS-1500 Medicare Professional Crossover Claim Form Filing Instructions

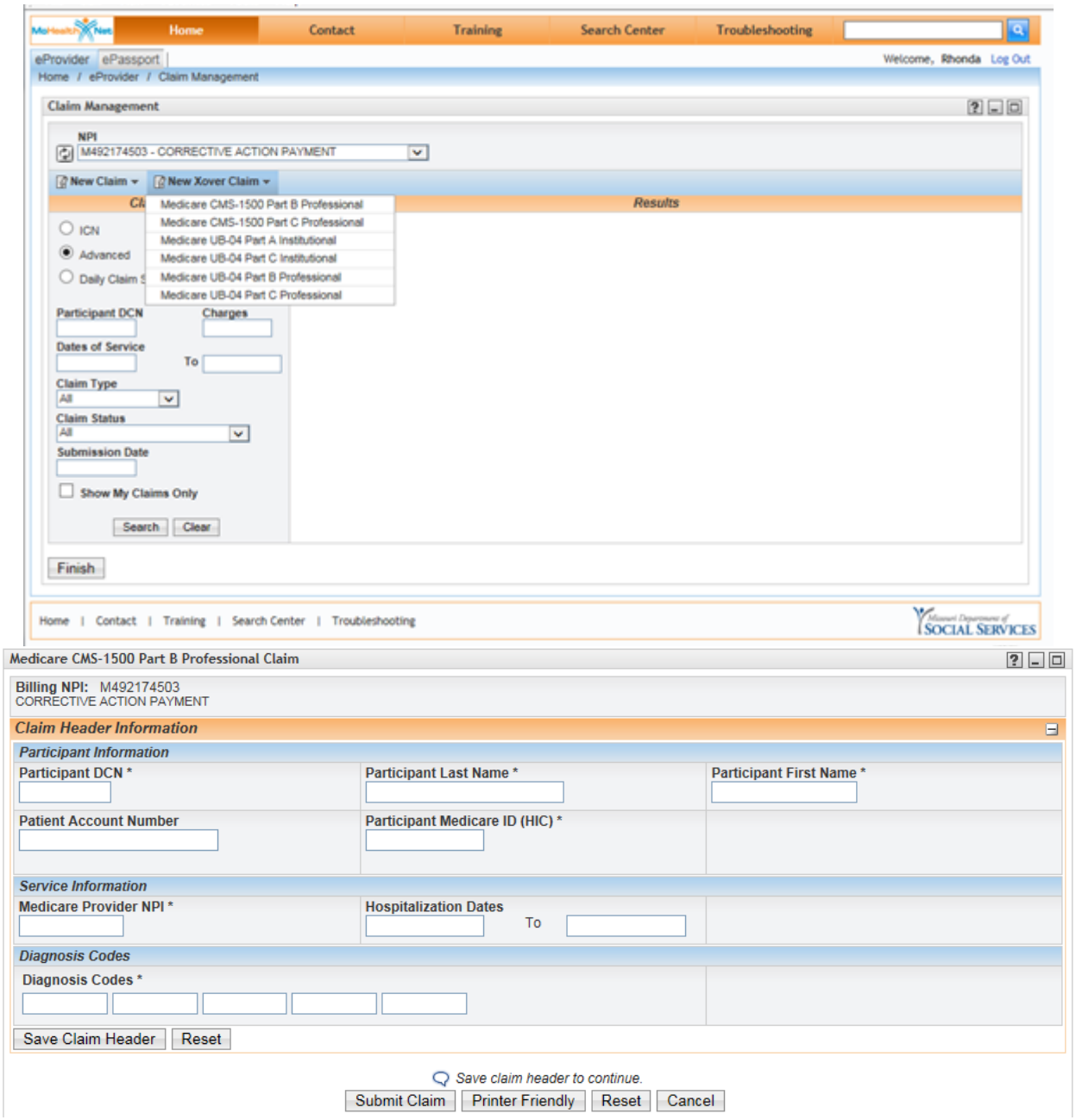


Welcome to eProvider

Select Claims Management

Select New Medicare Crossover Claim

Select the appropriate crossover claim type from the drop down list to begin a new crossover claim.

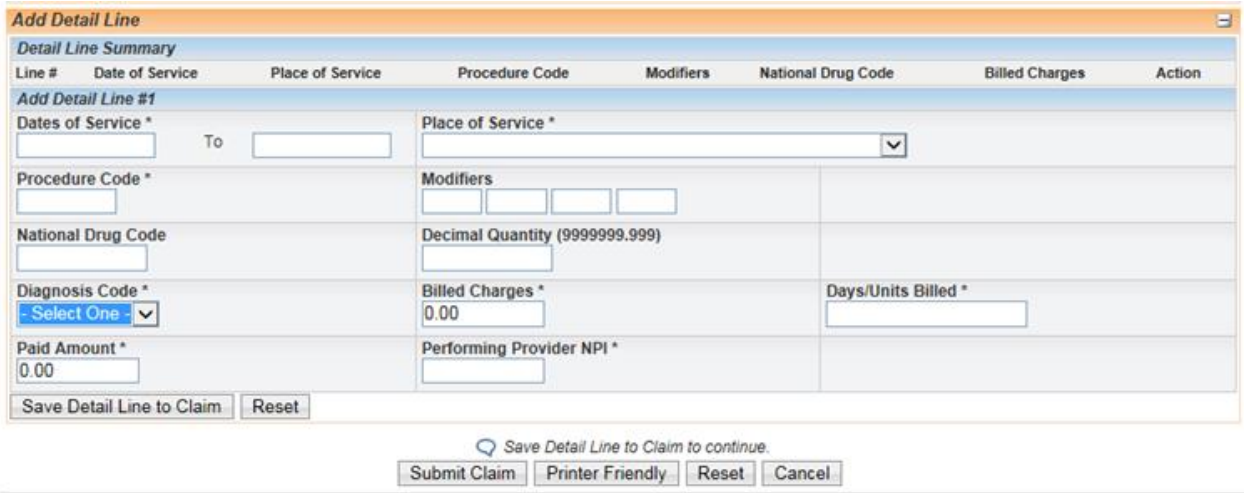


NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Claim Header Information Instructions for completion

Note: Previous instructions for the Claim Header Information apply to CMS-1500 Medicare Part B and Medicare Part C-QMB Professional claim with the addition of two required fields.

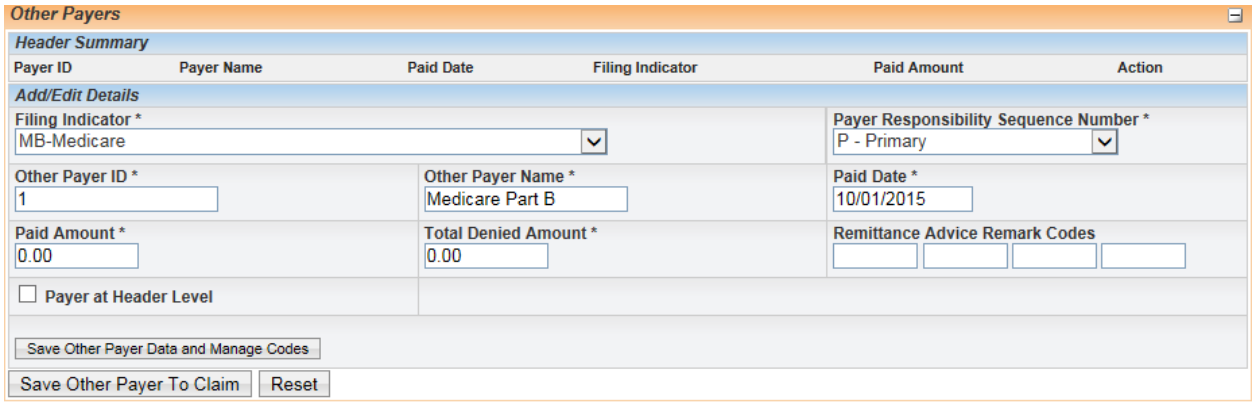
Participant Medicare ID (HIC)* Health Insurance Claim Number	Enter the Medicare beneficiary identification number that consists of 9 numbers immediately followed by an alpha suffix.
Medicare Provider NPI*	Enter the Medicare Provider NPI number used to bill this claim to Medicare.

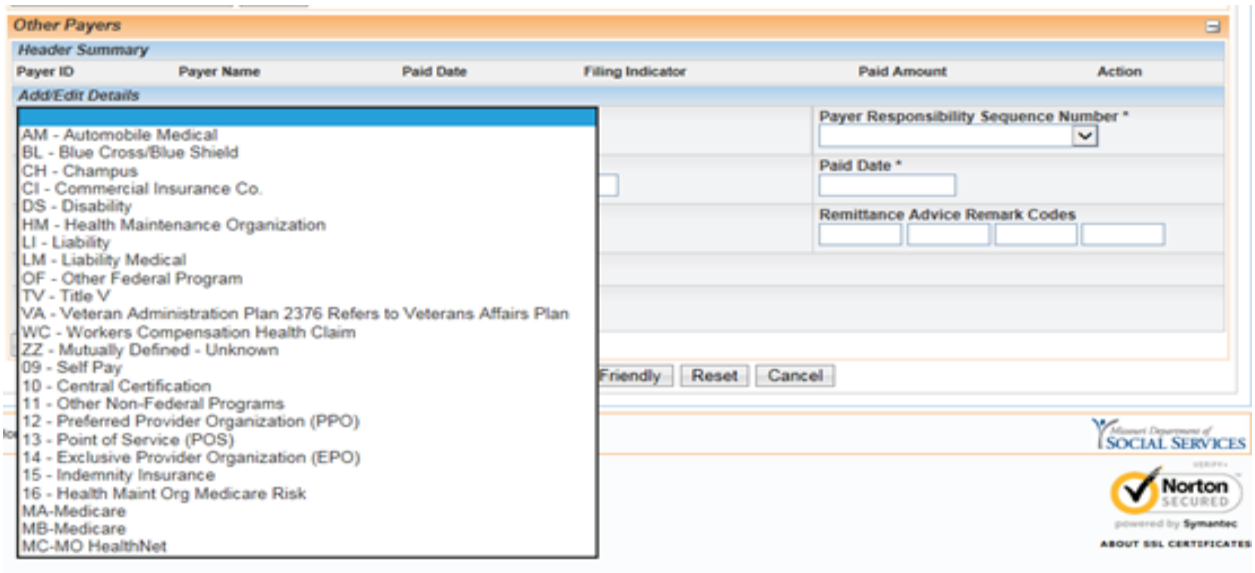


Add Detail Line Summary **Instructions for completion**

Note: Previous instructions for the Add Detail Line Information apply to CMS-1500 Medicare Part B and Medicare Part C- QMB Professional claim.

Performing Provider NPI*	Enter the MO HealthNet Provider Identifier (NPI) / Taxonomy code (if necessary) of the Performing Provider for each detail line.





Other Payer Attachment * **Instructions for completion**

Note: Previous instructions for the Add Other Payer Header Summary Information apply to CMS-1500 Medicare Part B and Medicare Part C- QMB Professional claim.

Filing Indicator* — Select the filing indicator that defines the type of other payer. For Crossover claims, at least one Other Payer Header Information form must be completed for Medicare with an **MB** (Medicare Part B) or **16** (Medicare Part C-QMB eligible participants only) in this field.

Note: Eligibility benefit of Insurance Type HN **with** QMB indicates Medicare Part C coverage (crossover claim).

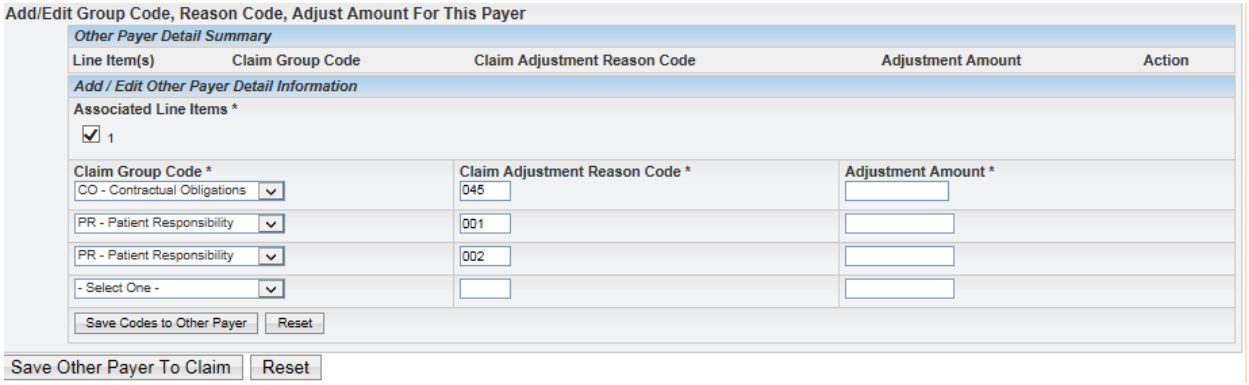
Note: Eligibility benefit of Insurance Type HN **without** QMB indicates Medicare Part C coverage (coordination of benefits claims).

Paid Date* — Enter the date Medicare payer paid.

Note: Medicare Part B and B of A claims should have at least one group, reason, or adjustment amount at the detail. These claims are paid off of detail only.

Remittance Advice Remark Codes — Enter the HIPAA approved X12 remittance remark code reported from this claim on the remittance advice or claim status response received from the other payer.

Payer at Header Level (checkbox) — Check the box if the other payer is at the header level.



Note: If you select a **Group Code**, you must complete the **Reason Code** field and the **Adjustment Amount** field. If you do not have information to enter in these fields, this field should be blank. Adjustment amount of zero is acceptable when appropriate.

MEDICARE ONLY
Part B paper remittance advices do not show an adjustment **group code** for the deductible and coinsurance. Enter group code **"PR"** to report the deductible and coinsurance. Part C paper remittance advices do not show adjustment group code for the copay; enter group code **"PR"** to report the copay.

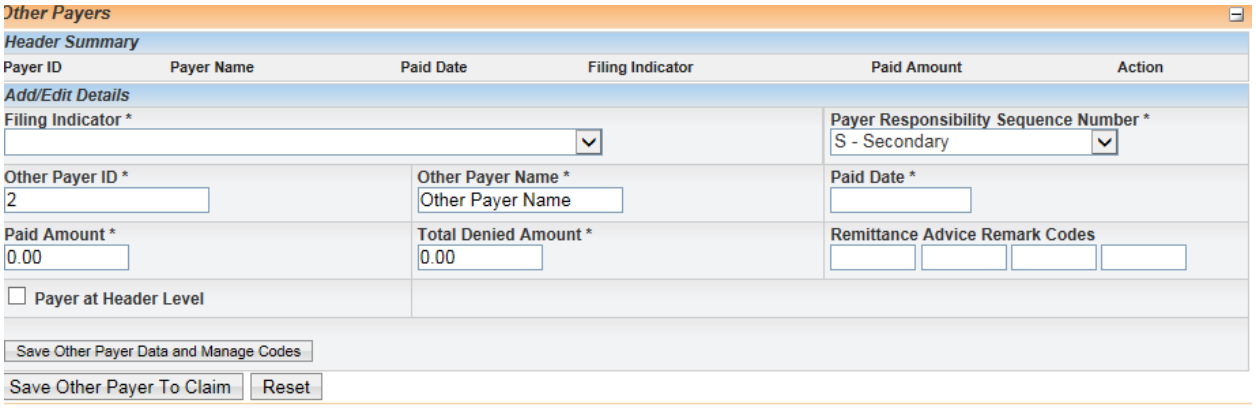
Claim Adjustment Group Code*	Enter the HIPAA-approved X12 (Medicare) adjustment **group code** reported for this claim on the remittance advice.
Claim Adjustment Reason Code*	Part B paper remittance advices do not show adjustment **reason** code for the deductible and coinsurance. Enter **"001"** for billing deductible and **"002"** for coinsurance. Part C paper remittance advices do not show adjustment reason code for the copay. Enter **"003"** for billing copay.
Adjustment Amount*	Enter the Adjustment Amount(s), including decimals, reported for this claim on the remittance advice or claim status response received from Medicare. The Adjustment Amount(s) is the amount that was NOT paid by Medicare, thus adjusting the reimbursement or covered amount from the submitted charge. The adjustment amount(s) reflects the difference between the submitted charge and the amount that was paid by Medicare.

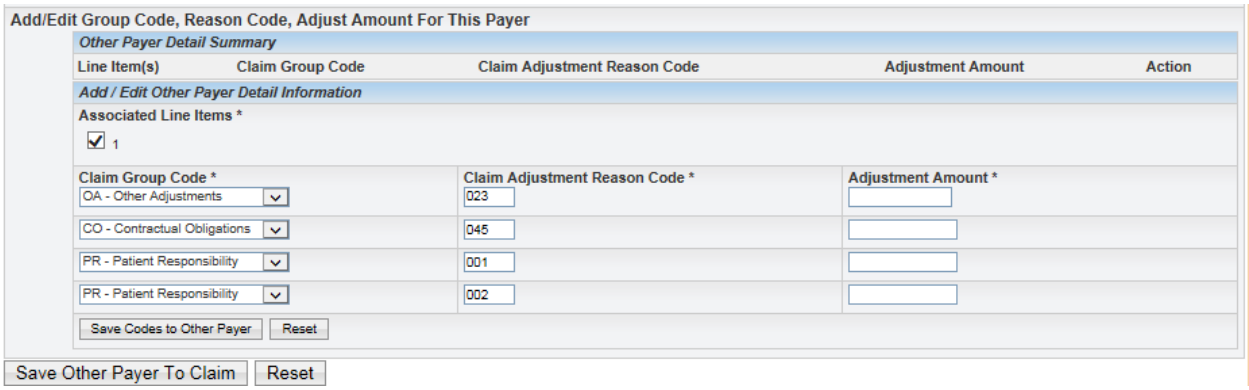
When multiple adjustments are reported each adjustment amount should be entered as reported.

Example:
Submitted Charge $100.00
Medicare Paid $ 70.00
Adjustment Amt. $ 30.00

Save Code to Other Payer	Select Save Code to Other Payer to save the Group code, Reason Code and Adjustment amount information.
Reset / Cancel (Other Payer Detail)	Select Reset/Cancel to clear all entered data from the Other Payer detail form.
Save Other Payer to Claim	Select Save Other Payer to claim to save the Other Payer claim dependent attachment.
Cancel (Other Payer Attachment)	Select Cancel to clear all unsaved data from the Other Payer Attachment.

MEDICARE WITH OTHER PAYER (Insurance) - An Other Payer form must be completed in addition to the Medicare related Other Payer form when there is **another payer** (supplemental insurance) involved.





Claim Adjustment Group Code*

Enter the HIPAA-approved X12 adjustment **group code** reported for this claim on the remittance advice or claim status response received from the Other Payer.

Claim Adjustment Reason Code*

When billing supplemental insurance, you must use a **group code/reason code** such as OA/023 to report the Medicare Paid Amount. Enter the HIPAA codes assigned by the other insurer or determined to be appropriate such as CO/045 to show any amount that was not paid by the insurer. These amounts must be reported for the claim to process.

Adjustment Amount(s)*

Enter the adjustment amount(s), including decimals, reported on the HIPAA compliant remittance advice. In the following example $950.00 is the sum of the adjustment amount(s) for the other payer.

Example: Calculation of Other Payer Adjustment

Amount billed to Medicare	$2000.00
Medicare Paid-	$1000.00
	$1000.00
Other Payer Paid-	$ 50.00
Adjustment Amount	$ 950.00

Payment by MO HealthNet, using the information provided above, and $110.00 as the deductible amount is shown below.

Medicare deductible amount	$110.00
Other payer paid-	$ 50.00
MO HealthNet payment amt.	$ 60.00

Save Code to Other Payer	Select Save Code to Other Payer to save the Group code, Reason Code and Adjustment amount information.
Reset l (Other Payer Detail)	Select Reset to discard Claim Group Codes, Claim Adjustment Reason Codes and Adjustment Amounts which have not previously been saved.
Save Other Payer to Claim	Select Save Other Payer to claim to save the Other Payer claim detail summary.
Reset	Select Reset to discard all other payer information entered which has not been previously saved.
Cancel (Other Payer Attachment)	Select Cancel to clear all unsaved data from the Other Payer Attachment.
Submit Claim (tab)	Select Submit Claim to submit the claim.
Printer Friendly (tab)	Select Printer Friendly to open the claim in a printer friendly PDF format.
Reset	Select Reset to discard all of the previously entered medical claim information.
Cancel	Select Cancel to discard all of the previously entered medical claim information and go back to the Claim Management page.

CMS-1500 Paper Claim Filing Instructions

The Centers for Medicare & Medicaid Services (CMS) -1500 (02-12) claim form should be legibly written or filled out electronically. The Behavioral Health Provider Manual Section 15 details the paper claim filling requirements.

MO HealthNet Division (MHD) paper claims should be mailed to the following address:

MO HealthNet Division
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field number and name		Instructions for completion
1.	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a.	Insured's I.D.*	Enter the patient's eight-digit MO HealthNet DCN (Departmental Client Number) as shown on the patient's identification card.
2.	Patient's Name*	Enter last name, first name, middle initial *in this order* as it appears on the patient's ID card.
3.	Patient's Birth Date, Sex	Enter month, day, and year of birth. Mark appropriate box.
4.	Insured's Name**	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

Field number and name		Instructions for completion
6.	Patient Relationship to Insured**	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.	Insured's Address**	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Reserved for NUCC Use (National Uniform Claim Committee)	Leave Blank.
9.	Other Insured's Name**	Enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Field Number 2. If no private insurance is involved leave blank. [See note (1)]
9a.	Other Insured's Policy or Group Number**	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.	Reserved for NUCC Use	Leave Blank
9c.	Reserved for NUCC Use	Leave Blank
9d.	Insurance Plan Name**	Enter the other insured's insurance plan or program name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* If no private insurance is involved, leave blank. [See Note (1)]
10a.-10c.	Is Condition Related to:**	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. **If the services are not related to an accident, leave blank.** [See Note (1)]

Field number and name		Instructions for completion
10d.	Claim Codes (Designated by NUCC)	Leave Blank.
11.	Insured's Group Policy or FECA Number**	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
11a.	Insured's Date of Birth, Sex**	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.	Other Claim ID** (Designated by NUCC)	Enter the "Other Claim ID". Applicable claim identifiers are designated by the NUCC.
11c.	Insurance Plan Name or Program Name**	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
11d.	Other Health Benefit Plan**	Indicate whether the patient has a secondary health insurance plan; if so, complete Field 9, 9a and 9d with the secondary insurance information. If no private insurance is involved, leave blank. [See Note (1)]
12.	Patient's or Authorized Person's Signature	Leave blank.
13.	Insured's or Authorized Person's Signature**	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance

Field number and name		Instructions for completion
		benefits from the policyholder.
14.	Date of Current Illness, Injury or Pregnancy**	*This field is required when billing global prenatal and delivery services*. The date should reflect the last menstrual period (LMP).
15.	Other Date	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.	Name of Referring Provider or Other Source**	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1) referring provider; 2) ordering provider; 3) supervising provider. *This field is required for independent laboratories and independent radiology groups and physicians with a specialty of "30" (radiology/radiation therapy).*
17a.	Other ID Number**	The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: OB State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) *This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).*
17b.	National Provider Identifier**	Enter the National Provider Identifier (NPI) number of the referring, ordering or supervising provider.

Field number and name		Instructions for completion
18.	Hospitalization Dates**	If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required when the service is performed on an inpatient basis.
19.	Additional Claim Information (Designated by NUCC)	Providers may use this field for additional remarks/descriptions.
20.	Outside Lab**	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.	Diagnosis*	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. Enter the diagnosis in the same order on all pages of claims with multiple lines. The International Classification of Diseases (ICD) indicator is not used.
22.	Resubmission Code**	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23.	Prior Authorization Number	Leave blank**.**
24a.	Date of Service*	Enter the date of service under “from” in month/day/year format using the six digit format in the unshaded area of the field. All line items must have a from date. A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days. The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines is shaded and is the location for reporting

Field number and name	Instructions for completion
	supplemental information. It is **not** intended to allow the billing of 12 lines of service.
24b. Place of Service*	Enter the appropriate place of service code in the unshaded area of the field.
24c. EMG-Emergency**	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency, leave this field blank.
24d. Procedure Code*	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.)
24e. Diagnosis Pointer*	Enter A, B, C, D or the actual diagnosis code(s) from field 21 in the unshaded area of the field.
24f. Charges*	Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown.
24g. Days or Units*	Enter the number of days or units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank. Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a.
24h. EPSDT/Family Planning**	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an EPSDT/HCY and Family Planning service enter "B."

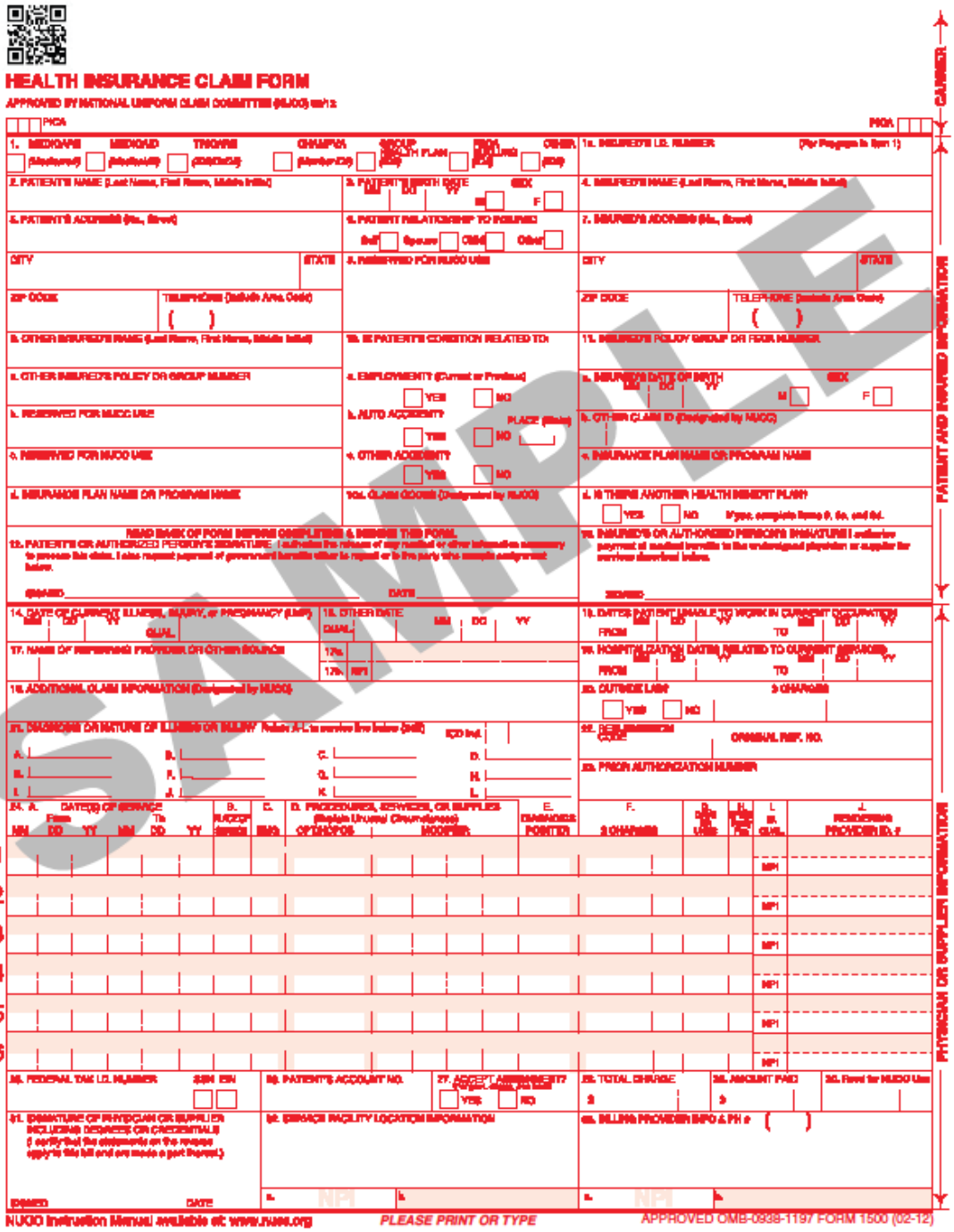
Field number and name		Instructions for completion
24L.	ID Qualifier**	Enter in the shaded area of 24L the qualifier identifying if the number is a non-NPI. The other ID number of the rendering provider should be reported in 24J in the shades area.
24j.	Rendering Provider ID**	The individual rendering the service is reported in this field. Enter the NPI number of the provider in the unshaded area of the field. This field is required for a clinic, radiology, teaching institution or a group practice only.
25.	Federal Tax ID Number	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	Assignment	Leave Blank.
28.	Total Charge*	Enter the sum of the line item charges.
29.	Amount Paid	Enter the total amount received by all other insurance resources. **Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30.	Reserved for NUCC Use	Leave Blank.
31.	Provider Signature	Leave Blank.
32.	Service Facility Location Information**	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.

Field number and name	Instructions for completion
32a. NPI Number**	Enter the NPI number of the service facility location reported in field 32.
32b. Other ID Number**	Enter number.
33. Provider Name/ Number /Address*	Affix the billing provider label or write or type the information **exactly** as it appears on the label.
33a. NPI Number*	Enter the NPI number of the billing provider listed in field 33.
33b. Other ID Number**	Enter number.

* These fields are mandatory on all CMS-1500 claim forms.

** These fields are mandatory only in specific situations as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **leave blank**. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.



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 MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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.

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)