STEP 1: ADMINISTRATION CLAIM

SAMPLE ADMINISTRATION CLAIM TO SUBMIT WITH DOSAGE-BASED ASSESSMENT

Payer & Address according to patient's card (never WVA). Only commercial payers and patients under 19. Out of state patient plans are o.k. – you may need to submit to local payer address.

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? PLACE (State) YES NO					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.

Complete Administration Claim as would occur with a normal claim.

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) **A good place to reference CPT and NDC of vaccine used if needed for payer, and/or processing notes to payer.**		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			Administration					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

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

STEP 2: DOSAGE-BASED ASSESSMENT

SAMPLE DOSAGE-BASED ASSESSMENT (DBA)

Payer & Address according to patient's card (never WVA). Only commercial payers and patients under 19. Out of state patient plans are o.k. – you may need to submit to local payer address.

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)

Complete similarly to Administration Claim, but with some adaptations.

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? PLACE (State) YES NO

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

A good place for processing notes to payer if needed.

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. Z 23 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 NDC DOS				See grid	No modifer	Tie to 21	See grid			NPI	Service provider NPI
2										NPI	Service provider NPI
3										NPI	Service provider NPI
4										NPI	Service provider NPI
5										NPI	Service provider NPI
6										NPI	Service provider NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN 27-2251833 ✔

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $ No charge to patient

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

Payers compare this to 24B place of service code

a. Enter provider NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Phone number is always Provider's billing office.
Washington Vaccine Association
PO Box 94002
Seattle, WA 98124-9402

a. 1699092718 b. 251K00000X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

Dosage-Based Assessment (837 Professional)

B	C	D	E	F	G	H
X12N 837, Version 5010A1		**Segment/**				**CMS-1500 Box**
Claim - Field Description	**Loop**	**Element**	**Qualifier**	**Qualifier Description**	**Data for WVA DBA Process**	**Crosswalk**
Billing Provider						
Federal Tax ID Number (TIN)	2010AA	REF01	E1	For EIN		None
TIN	2010AA	REF02			27-2251833	Box 25
Billing Provider Information	2010AA	NM101	85	Billing Provider		None
Billing Provider Entity Type	2010AA	NM102	2	Organization		None
Billing Organizational Name	2010AA	NM103			Washington Vaccine Association	Box 33
Identification Code Type	2010AA	NM108	XX	NPI		None
National Provider Identifier (NPI)	2010AA	NM109			1699092718	Box 33a
Billing Provider Taxonomy	2000A	PRV01	BI	Billing		None
Identification Qualifier Code	2000A	PRV02	PXC	Taxonomy		None
Identification Code Type	2000A	PRV03			251K00000X	Box 33b
Billing Provider Address	2010AA	N3			Leave Blank	None
Billing Provider Address - Line 1	2010AA	N301			1700 Seventh Ave	Box 33
Billing Provider Address - Line 2	2010AA	N302			Suite 1810	Box 33
Billing Provider City	2010AA	N401			Seattle	Box 33
Billing Provider State	2010AA	N402			WA	Box 33
Billing Provider ZIP Code	2010AA	N403			981011397	Box 33
Billing Provider Contact	2000A	PER01	IC	Information Contact		None
Identification Code Type	2000A	PER03	TE	Telephone Number		None
Billing Provider Telephone Number	2000A	PER04			Service Provider's Billing Office/ Contact Telephone Number	Box 33
Pay-To Provider Name	2010AB	NM101	87	Pay-To Provider	Washington Vaccine Association	None
Pay-To Entity Type	2010AB	NM102	2	Organization		None
Pay-To Address - Line 1	2010AB	N301			PO Box 94002	None
Pay-To City	2010AB	N401			Seattle	None
Pay-To State	2010AB	N402			WA	None
Pay-To ZIP Code	2010AB	N403			981249402	None
Patient Account Number	2300	CLM01				Box 26
Total Charge	2300	CLM02			Total Charge Amount	Box 28
	2300	CLM05-1	11	Office		Box 24B
Provider Signature Indicator	2300	CLM06	Y	Yes		Box 31
Note	2300	NTE				None
Note Reference Code	2300	NTE01	ADD	Indicates additional information for claim		Box 19
Note Text	2300	NTE02			Enter any free text notes about the claim	Box 19
Rendering Provider Name	2310B	NM1				None
Identification Code Type	2310B	NM101	82	Rendering Provider		None
Identification Code Type	2310B	NM102	1	Individual		None
Identification Code Type	2310B	NM108	XX	NPI		None
Identification Code Type	2310B	NM109			Rendering Provider's NPI #	Box 24J
Service Facility Location Information	2310C					None
Service Facility Identifier	2310C	NM101	77	Service Location		None
			FA	Facility	Use Office Address of Service Facility	None
Service Facility Type	2310C	NM102	2	Non-Person Entity		None
Service Facility Name	2310C	NM103				Box 32
Service Line, Service Date(s)	2400	DTP01	472	Date of Service		None
Service From - To Dates	2400	DTP02	RD8	Range of Dates of Service		None
Format as: CCYYMMDD-CCYYMMDD	2400	DTP03				Box 24A
Procedures, Services, Supplies	2400	SV1				None
Product/Service ID	2400	SV101-1	HC	Standard CPT Code		None
Procedure-CPT/HCPCS Code	2400	SV101-2				Box 24D
Line Item $ Charge Amount	2400	SV102				Box 24F
Drug Identification	2410	LIN				None
Product or Service Identification Code	2410	LIN02	N4	Must be N4 (No description given)		Box 24 Shaded area for service line
National Drug Code NDC #	2410	LIN03			**11-digit** NDC #	Box 24 Shaded area for service line
Drug Quantity	2410	CTP				None
Drug Unit Price	2410	CTP03			Unit price, based upon the unit of measure as defined by the NDC.	Box 24 Shaded area for service line
National Drug Unit Count/Quantity	2410	CTP04			Dispensing quantity, based upon the unit of measure as defined by the NDC.	Box 24 Shaded area for service line
Unit or Basis for Measurement Code	2410	CTP05-1			NDC unit or basis for measurement code (UN, ML, F2 or GR)	Box 24 Shaded area for service line