



RENDERING TAXONOMY REQUIREMENTS EFFECTIVE 11/01/2016

Cook Children's Health Plan is taking steps to improve the speed and accuracy in processing paper claims. While we highly encourage electronic claim submissions, should you find that you can only submit a claim on paper, please follow these tips:

- Print claim data within defined boxes on the claim form
- Handwritten claim forms cannot be accepted and will be returned
- Use all capital letters
- Print using 10-pitch Pica type(12-point) Courier font. Do not use fonts smaller or larger than 12 points. Do not use proportional fonts, such as Arial or Times Roman
- Do not use dashes or slashes in date fields
- Use paper clips on claims or appeals if they include attachments. Do not use glue, tape, or staples
 - Place the claim form on top when sending new claims, followed by any medical records or other attachments
 - Number the pages when sending attachments or multiple claims for the same Member (e.g., 1 of 2, 2 of 2)
 - Do not total the billed amount on each claim form when submitting multi-page claims for the same Member
 - Do not fold claims forms

Completion of the CMS 1500 also requires the following provider information:

- ZZ ID Qualifier in (24I Shaded)
- National Provider Identifier (NPI) of Rendering Provider (24J-Unshaded)
- Taxonomy Code (24J-Shaded)
- Billing Provider NPI (33a)
- Billing Provider Taxonomy Code (33b)
- If applicable, Referring, Ordering or Supervising Provider Name and NPI (17a & 17b)
 - If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19
 - The following qualifiers must be used:
 - DN = Referring Provider
 - DK = Ordering Provider
 - DQ = Supervising Provider
- If you do not have an NPI, place your Atypical Provider ID (API)/LTSS# in Box 33b

See reverse side for an example of the CMS 1500 requirements

Completion of the CMS1500 requires the following provider information:

Referring Provider:

17 Referring Provider Name

17b Referring Provider NPI

Rendering Provider

24I shaded ZZ Qualifier

24J shaded Rendering Provider Taxonomy Code

24J unshaded National Provider Identifier (NPI) of Rendering Provider

If you do not have an NPI, place your Atypical Provider ID (API)/LTSS# in Box 33b

Billing Provider

33a unshaded Billing Provider NPI

33b shaded Billing Provider Taxonomy Code (or API # if no NPI)

Claim Analysts are available
Monday- Friday
8:00am to 5:00pm (CST)
800-964-2247 phone
682-885-8404 fax



HEALTH INSURANCE CLAIM FORM

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

| | | | | | | | | | | | |
|---|--|---------------------------|---------------------------------------|--|--|--|--|---|--|---|--|
| <input type="checkbox"/> PICA <input type="checkbox"/> PICA | | | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (TRICARE#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA B/L (LUNG) <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#) | | | | 1a. INSURED'S ID NUMBER (For Program in Item 1) | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY | | SEX M <input type="checkbox"/> F <input type="checkbox"/> | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | 7. INSURED'S ADDRESS (No., Street) | | | |
| CITY | | | STATE | | | 8. RESERVED FOR NUCC USE | | | CITY | | |
| ZIP CODE | | | TELEPHONE (Include Area Code) () () | | | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | 10. IS PATIENT'S CONDITION RELATED TO: | | |
| 9a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | 9b. RESERVED FOR NUCC USE | | 9c. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> | | 9d. INSURED'S DATE OF BIRTH MM DD YY | |
| 9e. RESERVED FOR NUCC USE | | | | | | 9f. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> | | 9g. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 9h. OTHER CLAIM ID (Designated by NUCC) | |
| 9i. RESERVED FOR NUCC USE | | | | | | 9j. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. CLAIM CODES (Designated by NUCC) | | | |
| 9k. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | 9l. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d. | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | |
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorizes the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process the 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 the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: _____ DATE: _____ | | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | | | | 15. OTHER DATE QUAL MM DD YY | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Referring Provider | | | | | | 17a. NPI | | 17b. NPI Number | | | |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | 19. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES | | | | | |
| 20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-C to service line below (24E)) ICD Ind. | | | | | | 21. RESUBMISSION CODE ORIGINAL REF. NO. | | | | | |
| 22. PRIOR AUTHORIZATION NUMBER | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | B. PLACE OF SERVICE EMG | | C. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS) MODIFIER | | D. DIAGNOSIS POINTER | | E. \$ CHARGES | | F. \$ CHARGES | |
| G. DATES OR UNITS | | H. EPICR Rank (in) | | I. IS, | | J. RENDERING PROVIDER'S | | K. TAXONOMY | | L. NPI | |
| 25. FEDERAL TAX ID NUMBER SSN EIN | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For group health, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> | | 28. TOTAL CHARGE \$ | | 29. AMOUNT PAID \$ | | 30. Rsvd for NUCC Use | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | 33. BILLING PROVIDER INFO & PH # () | | |
| SIGNED: _____ DATE: _____ | | | | | | 34. NPI | | 35. Billing NPI | | 36. Billing Taxonomy | |

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMS FORM 10088-107 (02/12) (FORM 10088-107)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION