Field	Description	Required	Additional Explanation
NA	Carrier Block	Yes	Enter the name and address of the insurance carrier being billed.
1	Type of Insurance	No	
1A	Insured's ID Number (HIC)	Yes	Enter the patient's insurance identification number as listed on their card.
2	Patient's Name	Yes	Enter the patient's name as it appears on the insurance identification card.
3	Patient's Birth Date, Sex	Yes	Enter the patient's DOB and sex. The DOB is required, while the patients' sex is optional.
4	Insured's Name	No	
5	Patient's Address	Yes	Enter the patient's address, if patient is homeless or address is unknown enter NKA, No Known Address, Unknown or Homeless.
6	Patient Relationship to Insured	No	
7	Insured's Address	No	Required only if box 4 is completed.
8	Reserved for NUCC Use (previously Patient Status)	DO NOT USE	
9	Other Insured's Name	No	
9A	Other Insured's Policy or Group Number	No	
9B	Reserved for NUCC Use (previously Other Insured's Date of Birth, Sex)	DO NOT USE	
9C	Reserved for NUCC Use (previously Employer's Name or School Name)	DO NOT USE	
9D	Insurance Plan Name or Program Name	No	
10A	Is Patient's Condition Related to Employment	No	
10B	Is Patient's Condition Related to Auto Accident	No	Not Required but if marked Yes, state must be indicated.

Field	Description	Required	Additional Explanation
10C	Is Patient's Condition Related to Other Accident	No	
10D	Claim Codes (previously Reserved for Local Use)	No	
11	Insured's Policy, Group, or FECA Number	No	
11A	Insured's Date of Birth, Sex	No	
11B	Other Claim ID (previously Insured's Employer Name or School Name)	No	
11C	Insurance Plan Name or Program Name	No	
11D	Is there another health benefit plan?	No	
12	Patient's or Authorized Person's Signature	Yes	Enter the patient's or authorized person's signature. Signature on File or "SOF" are acceptable. If the claim is for a Lab or DME provider "No Signature on File" or "Patient Not Present are also acceptable."
13	Insured's or Authorized Person's Signature	Situationally Required	Enter the patient's or authorized person's signature. Signature on File or "SOF" are acceptable. If the claim is to be paid to member enter "Pay to Member."
14	Date of Current Illness, Injury, Pregnancy (LMP)	No	
15	Other Date (previously If Patient Has Had Same or Similar Illness)	No	
16	Dates Patient is Unable to Work in Current Occupation	No	
17	Name of Referring/Ordering ProviderQualifier DN = Referring Provider DK = Ordering Provider DQ = Supervising Provider	Situationally Required	Enter referring or ordering provider information, including the provider qualifier, first and last name, and NPI. Lab, DME, and Radiology claims require Ordering Physician to be entered.
17A	Other ID#	No	

Field	Description	Required	Additional Explanation
17B	Referring/Ordering NPI	Situationally Required	Required for Lab, DME, and Radiology claims.
18	Hospitalization Dates Related to Current Services	Situationally Required	Required when services furnished as result of hospitalization.
19	Additional Claim Information (previously Reserved for Local Use)	No	
20	Outside Lab Charges	No	
21	Diagnosis or Nature of Illness or Injury	Yes	Enter the appropriate ICD indicator for the date of service.
22	Resubmission and/or Original Reference Number	Situationally Required	Enter frequency code "7" along with the original claim number if submitting a corrected claim.
23	Prior Authorization Number or CLIA Number or Mammography Certification Number	No	
24 Shaded	Section 24	Situationally Required	Enter NDC information here. Include the NDC, units, and units of measure. Claim will be denied if NDC is required but missing. Enter DME descriptions. Claim will be denied if a description is required but missing. Enter unspecified 99 code descriptions. Enter anesthesia time spans and minutes.
24A	Date(s) of Service	Yes	Enter both the "From" and "To" dates. If only one date is billed enter it under the "From" date.
24B	Place of Service	Yes	Enter the two digit Place of Service Code for each item or service billed.
24C	EMG	No	Enter Y for "YES" or leave blank if "NO"
24D	Procedures, Services, or Supplies	Yes	Enter the CPT or HCPCS code and modifier (if applicable) for each item or service billed.

Field	Description	Required	Additional Explanation
24E	Diagnosis Pointer	Yes	Enter the related diagnosis pointer(s) from box 21, A-L. Only alpha pointers will be accepted. Claims with numeric pointers or pointers to blank alpha fields from box 21 will be returned for correction.
24F	$ Charges (Billed Amount)	Yes	Enter the charge amount for each item or service billed.
24G	Days or Units Billed	Yes	Enter the number of days or units associated with the item or service billed.
24H	EPSDT/Family Plan	No	
24I Shaded Line	ID Qualifier	No	
24J Shaded Line	ID Qualifier	No	
24J	Rendering Provider ID # (NPI)	Situationally Required	Required when billed with a rendering provider. If billing locum tenens provider the locum information must be entered here.
25	Federal Tax ID or SSN	Yes	Enter the billing provider's Tax ID or SSN of the provider billed in box 33
26	Patient's Account Number	No	
27	Accept Assignment	Situationally Required	Enter an X in the correct box noting if assignment is accepted. This is required when billing claims to Samaritan Advantage, dual (Medicare and Medicaid) covered members, and contracted providers.
28	Total Charge (Billed Amount)	Yes	Enter the total billed for all line items combined. Multiple page claims should be totaled on the last page, with "continued" indicated on all other pages.
29	Amount Paid (by Patient)	No	
30	Reserved for NUCC Use (previously Balance Due)	DO NOT USE	

Field	Description	Required	Additional Explanation
31	Signature of Physician or Supplier Including Degrees or Credentials	Yes	Enter the provider, supplier, or their representative's legal signature, along with the date the form was signed. "Signature on File" or "SOF" are also acceptable.
32	Service Facility Location	Situationally Required	Required for independent labs, DME, prosthetic providers, and providers with multiple service locations. For Ambulance claims enter both the To and From facilities or addresses. CSZ is required for Ambulance claims (If not enough space for destination information in Item 32, utilize Item 19 narrative)
32A	Service Facility NPI	No	
32B	Service Facility Other ID#	No	
33	Billing Provider Info and Phone #	Yes	Enter the provider or supplier's billing name, address, ZIP code, and phone number.
33A	Billing Provider NPI	Yes	Enter the provider or supplier's NPI.
33B	Billing Provider Other ID#	No	

Samaritan Health Plans

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

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) — R

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — R

3. PATIENT'S BIRTH DATE MM DD YY — R; SEX M ☐ F ☐

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

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

6. PATIENT RELATIONSHIP TO INSURED — Self ☐ Spouse — N — Child ☐ Other ☐

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

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) — N

10. IS PATIENT'S CONDITION RELATED TO: — S

11. INSURED'S POLICY GROUP OR FECA NUMBER — N

a. OTHER INSURED'S POLICY OR GROUP NUMBER — N

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY — N; SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) — S

b. OTHER CLAIM ID (Designated by NUCC) — N

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME — N

d. INSURANCE PLAN NAME OR PROGRAM NAME — N

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ — N — 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 — R — 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 — S

PATIENT AND INSURED INFORMATION

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

15. OTHER DATE QUAL. — N — DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — S

17a. — N

17b. NPI — S

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ — N — $ CHARGES

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

A. — R B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE — S — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER — N

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	R	R	N	R	S	R	R	R	N	NPI	S
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN — R

26. PATIENT'S ACCOUNT NO. — N

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

28. TOTAL CHARGE $ — R

29. AMOUNT PAID $ — N

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 — R — DATE

32. SERVICE FACILITY LOCATION INFORMATION — S

a. — N — b. — N

33. BILLING PROVIDER INFO & PH # ( ) — R

a. — R — b. — N

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Required | **Situational** | **Not Required**