

BLK No.	Block Description
1	<b>Type of Claim LB</b> Do not complete this block.
1a	<b>Insured's ID Number R</b> Enter the Member's ID. Must be 8 Characters. Note: Include any leading zeros.
2	<b>Patient's Name R</b> Patient Last Name and First name (e.g., Doe, John) Submit utilizing exact name provided on ID card (HC Only).
3	<b>Patient's Birthdate and Sex R</b> Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578). Indicate the patient's gender by placing an X in the appropriate box.
4	<b>Insured's Name R</b> Member's Last Name and First name (e.g., Doe, John) Submit utilizing exact name provided on ID card.
5	<b>Patient's Address R</b> Enter the patient's address.
6	<b>Patient's Relationship to the Insured R</b> Enter an "X" in the appropriate box. Select only one.
7	<b>Insured's Address R</b> Enter Member's Address.
8	<b>Patient Status LB</b> Do not complete this block.
9	<b>Other Insured's Name A</b> If the patient has another health insurance secondary to the insurance indicated in Block 11d, enter the last name, first name, and middle initial of the insured.
9a	<b>Other Insured's Policy and Group Number A</b> If information is entered in Block 9, enter Other insured's Policy and Group Number of Insured's name in Block 9. <b>LB</b> if no information listed on Block 9.
9b	<b>Other Insured's Date of Birth and Sex LB</b> Do not complete this block.
9c	<b>Employer's Name or School Name LB</b> Do not complete this block.
9d	<b>Insurance Plan Name or Group Name R</b> If information is entered in Block 9, enter Insurance Plan Name or Group Name of Other Insured's name in Block 9. <b>LB</b> if no information listed on Block 9.
10a-10c	<b>Is Patient's Condition Related To: A</b> Complete the block by placing an X in the appropriate YES or NO box to indicate whether the patient's condition is related to employment or auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. Do not complete state box field.
10d	<b>Reserved For Local Use O</b> Enter a "C" for a corrected claim in this field.
11	<b>Insured's Policy Group or FECA Number LB</b> Do not complete this block.
11a	<b>Insured's Date of Birth and Sex R</b> Enter Member's date of birth and Sex of Insured's name in Block 11. Enter date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578). Indicate the Member's gender by placing an X in the appropriate box.
11b	<b>Employer's Name or School Name LB</b> Do not complete this block.
11c	<b>Insurance Plan Name or Program Name LB</b> Do not complete this block.
11d	<b>Is There Another Health Benefit Plan? R</b> Place an X in the appropriate box. If yes, complete Blocks 9, 9a and 9d.
12	<b>Patient's or Authorized Person's Signature and Date R</b> Enter patient's or authorized person's signature. Enter date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578).
13	<b>Insured's or Authorized Person's Signature R</b> Enter Member's or authorized person's signature. Enter date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) or six-digit format MMDDYY (month, day, and year) format (e.g., 021578).
14	<b>Date of Current: O</b> If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, year) format (e.g., 030104).
15	<b>If Patient Has Had Same or Similar Illness A</b> If the patient had the same or similar illness list first date of occurrence in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, year) format (e.g., 030104).
16	<b>Dates Patient Unable to Work in Current Occupation LB</b> Do not complete this block.
17	<b>Name of Referring Physician or Other Source A</b> Enter name of the Referring Physician or other source such as a clinic or facility.
17a	<b>Taxonomy of Referring Physician or Other Source A</b> Provider Taxonomy Code (Provider Specialty Code).
17b	<b>NPI of Referring Physician or Other Source LB</b> Enter the National provider Identifier (NPI) number of name entered in Block 17.

18	<b>Hospitalization Dates related to current services A</b> When the serving/billing provider's services charged on this claim are related to a patient's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Date should be in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004) or in six-digit MMDDYY (month, day, and year) format (e.g., 030104)
19	<b>Reserved For Local Use LB</b> Do not complete this block.
20	<b>Outside Lab? LB</b> Do not complete this block.
21	<b>Diagnosis or Nature of Illness or Injury R</b> Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. The primary ICD-9 code or the ICD-10-code (21.1) must be completed.
22	<b>Resubmission Code A</b> Enter 7 for replacement of prior claim or 8 for void/cancel of prior claim. <b>R Original Ref. No.</b> if Resubmission Code entered.
23	<b>Prior Authorization Number LB</b> Enter the Prior Authorization Number.
24a	<b>Dates of Service R</b> Enter the applicable date(s) of service in an 8-digit format. If billing for a service that was provided on one day only, complete the From date of service only. If the same service was provided on consecutive days, enter the first day of the service in the From column and the last day of service in the To column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g., 03012004) or a six-digit format (MMDDYY) to record From and To dates (e.g., 030104). If the dates are not consecutive, separate claim lines must be used.
24b	<b>Place of Service R</b> Enter the 2-digit national standard place of service code that indicates where the service was performed. Examples: 11—Office, 22—Hospital, 23—ECF, 99—Other.
24c	<b>EMG A</b> Enter "Y" if the service provided was in response to an emergency, otherwise, leave this block blank.
24d	<b>Procedures, Services, or Supplies (CPT/HCPCS &amp; Modifier) R/AAAA</b> List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to 3 additional informational modifier(s) when applicable. If no pricing modifier is required, enter up to 4 additional/informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.
24e	<b>Diagnosis Pointer R</b> This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 2.1), enter 1. If provided for the secondary diagnosis, enter 2. If provided for the third diagnosis, enter 3, and for the fourth diagnosis, enter 4.
24f	<b>\$Charges R</b> Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter 6500.
24g	<b>Days or Units R</b> Enter the number of units, services, or items provided. Can enter decimal (e.g., 5.1) but cannot be more than 8 digits. For anesthesia/CRNA, please provide minutes only.
24h	<b>EPSDT/Family Planning LB</b> Do not complete this block.
24i	<b>ID Qualifier LB</b> Do not complete this block.
24j (a)	<b>Rendering Provider ID # (shaded) LB</b> Do not complete this block.
24j(b)	<b>NPI (not shaded) R</b> Enter the ten digit NPI number of the rendering provider.
25	<b>Federal Tax I.D. Number R</b> Enter Federal tax number of the entity to whom payment is expected to be issued to and place an X in the appropriate block. Cannot be greater than nine digits
26	<b>Patient's Account Number O</b> Use of this block is strongly recommended. It can contain up to 20 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name.
27	<b>Accept Assignment? R</b> Must put an "X" in either the "yes" box or the "no" box but not in both.
28	<b>Total Charge R</b> Total charges of all details on the claim. Total charge must be greater than zero. Format example, if total charge is sixty-five dollars, enter 6500. Multiple page claims are not allowed. If detail requires more than one claim, each claim must be considered a separate claim with its own total charge.
29	<b>Amount Paid O</b> Patient payment at time of visit. If entered must be numeric. For example if amount paid is sixty-five dollars, enter 6500.
30	<b>Balance Due R</b> From the total charge, subtract amounts received from other sources and enter the result.
31	<b>Signature of Physician or Supplier Including Degree or Credentials R</b> The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction.
32	<b>Service Facility Location Information R</b> Enter name and address where service was performed. Zip code must be nine digits (e.g., 770513246).
32a	<b>R</b> Enter the National Provider Identifier (NPI) number of the Service Facility Location.
32b	<b>LB</b> Do not complete this block.
33	<b>Billing Provider Info &amp; Ph.# R</b> Enter name and address. Zip code must be nine digits (e.g. 770513246).
33a	<b>R</b> Enter the ten digit NPI number of the billing provider
33b	<b>LB</b> Do not complete this block.