

Submission Example

Please refer to the NUCC (National Uniform Claim Committee Guide) for complete detailed information on paper claim submission as well as the 837 Professional Implementation Guide for any Electronic Data Interchange (EDI) issues.

Please contact the EDI Ops Team at EDI-Master@wellcare.com for assistance to send your claims by EDI.



HEALTH INSURANCE CLAIM FORM

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

PICA											PICA																
1. MEDICARE <input type="checkbox"/> (Medicare#)				MEDICAID <input type="checkbox"/> (Medicaid#)			TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (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 <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				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: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER				a. INSURED'S DATE OF BIRTH MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				b. RESERVED FOR NUCC USE				c. RESERVED FOR NUCC USE				d. INSURANCE PLAN				e. OTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES (If yes, complete items 9, 9a, and 9d.)											
12. PATIENT'S ORAL SIGNATURE to process this claim below.								13. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Donald Duck				17a. ZZ 1234567890 NPI 9876540123				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				19. AUTHORIZED PERSON'S SIGNATURE I authorize medical benefits to the undersigned physician or supplier for use below.							
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				20. RESUBMISSION CODE ORIGINAL											
21. NDC - National Drug Code The Provider should populate a valid NDC for drugs. The code must be entered in the shade area of Box 24. The "N4" qualifier must precede the 11 digit NDC code. No spaces or dashes are allowed.								22. RESUBMISSION CODE ORIGINAL				23. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				24. TOTAL CHARGE \$				25. AMOUNT PAID \$		30. Asvd for NUCC Use					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY								B. PLACE OF SERVICE EMG				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/CS MODIFIER				E. DIAGNOSIS DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSTD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1																				ZZ NPI		1234567890 9012345678					
2																				NPI							
3																				NPI							
4																				NPI							
25. FEDERAL TAX I.D. NUMBER 9 digit Federal Tax ID								26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Asvd 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.) Rendering Provider's LastName, FirstName								32. SERVICE FACILITY LOCATION INFORMATION Service Facility Name Physical Location City, State, Zip				33. BILLING PROVIDER INFO & PH # Billing Provider Name Payment Location City, State, Zip				a. NPI of Service Facility		b. ZZ qualifier 10 digit Taxonomy Code									

The name of the Referring, Ordering or Supervising provider is entered in Box 17. If Box 17 is populated with a name then the qualifier must be placed in the left section of Box 17.
Example: DN|Donald Duck
Qualifiers: DN - Referring, DK - Ordering, DQ - Supervising
The provider's NPI must be listed in Box 17b.
The provider's Taxonomy Code can be entered in Box 17a with the qualifier ZZ preceding the 10 character Taxonomy Code

Rendering Provider's Taxonomy Code is entered in Box 24J (shaded area) and the "ZZ" qualifier in 24I
Note: Do not populate 24J if Box 31 and 33 are the same.

NDC - National Drug Code
The Provider should populate a valid NDC for drugs. The code must be entered in the shade area of Box 24. The "N4" qualifier must precede the 11 digit NDC code. No spaces or dashes are allowed.

If Rendering Provider is populated in Box 31 then the Rendering Provider's NPI is Required in Box 24J

Service Location Box 32
Address MUST be the physical address where services were rendered.
Address can NEVER be a PO Box address.
Address is required when different from the Bill To Address.
Address is not required if the place of service is 12 or 15 (Home or Mobile Unit).

Bill to Provider Box 33 requires mailing address (where the provider wants the payments to go)
Box 33a requires NPI of the Bill To Provider
Box 33b - Taxonomy code preceded with "ZZ" qualifier of the Bill To Provider

Federal Tax ID Box 25
Federal Tax ID Number is required.

Rendering Provider's Name is Required in Box 31 if different from Bill To Provider. Type Rendering Provider's name in the blank area above the preprinted "SIGNED" and "DATE"

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION