Section 19

Claim Submission

Contents

Claim Submission Requirements

The requirements in this section help reduce administrative waste and increase efficiency. Please ensure your billing team follows these guidelines to avoid claim processing and payment delays.

Electronic claim submission

Blue Cross® Blue Shield® of Arizona (AZ Blue) generally requires electronic submission of all claims (EDI payer ID 53589). You can track and balance your submitted claims with the automatically-generated 999 and 277CA acknowledgment electronic reports and the custom claims acknowledgment report (CCAR) summary (see page 19 -18).

How to submit claims electronically

AZ Blue supports the following options for electronic claim submission:

- **Availity Essentials™ provider portal**
  You can submit claims (professional, institutional, and dental) through the Availity Essentials provider portal at no charge to you. This includes a streamlined "Quick Claims" option (for professional claims) that allows you to submit multiple claims (in a batch) to one or more payers. If you're not registered yet, visit Availity's Register and Get Started page.
- **Third-party clearinghouse**
  You can also conduct electronic business through a third-party clearinghouse. AZ Blue is networked to multiple national clearinghouses that do business in Arizona. For a current list of these clearinghouses, visit our Electronic Options page under "Getting Started with Electronic Transactions."

Timely filing

We ask providers to submit complete and accurate claims within 30 days of service. Generally, we deny payment of any claims received more than one year after the date of service. Members are not liable for payment of a claim denied for untimely filing. For Federal Employee Program® (FEP®), the claim submission deadline is December 31 of the year after the year the service was rendered.

Proof of timely filing

Proof of timely filing must be submitted with grievances related to claims denied because of untimely filing. For more information about provider grievances, see Section 22. For proof of timely submission, you can submit a copy of the CCAR summary, showing receipt of a clean claim within one year of the date of service.

Tax identification number (TIN) claim edits

Our claim processing system includes TIN edits to filter out and reject claims that have one or more of the following errors:

- Billing tax ID not valid for date of service
- NPI/tax ID combination not in our database for rendering provider
- NPI/tax ID combination not in our database for billing provider

The qualifiers SY (SSN) and EI (EIN) are both used in determining the TIN. To update our systems with your current information, use the online Provider Information Change Form, available in the AZ Blue provider portal at > Provider Resources > Forms > Provider Information Change.

"Clean" claim requirements

You can avoid claim processing delays by submitting "clean" claims that can be adjudicated immediately without further information from you or a third party, except when a review of medical records is required.

Claim Submission Requirements

Here's a checklist of some key requirements for clean claims:

- ☐ Accurate and complete information identifying the patient and subscriber (if different from patient) with correct and complete names, identification numbers, and dates of birth

  Note: The member ID prefix you enter must match the prefix we have on file for the service date. If not, you will receive the following message:

  "The member ID prefix you entered does not match the prefix on file for this service date. Please resubmit with the correct prefix (see azblue.com/prefix)."

- ☐ Date and place of service
- ☐ Identification of the service(s) provided by appropriate diagnosis code(s), procedure code(s), and modifiers if appropriate
- ☐ Evidence that any required prior authorization was obtained
- ☐ Identification of the billing, servicing/rendering, and referring providers, including tax ID and NPI numbers, and other codes as indicated in the following table (for dental claims, see Section 26)

LOOP	ELEMENT	HCFA BOX	DESCRIPTION	AZ BLUE REQUIREMENTS
2000A	PRV03	33b	Taxonomy code	For 837P and 837D, the taxonomy code is required.
2010AA	NM102	33	Billing entity code	If you are a sole proprietor (solo practitioner), the entity type qualifier code 1 (for a person) is required. If you are a group, the entity-type code 2 is required. This requirement applies to both professional and dental claims.
2010AA	NM103	33	Billing provider info	If the tax ID is for a group practice, rather than an individual provider, you must include the *group practice* name here.
2010AA	NM109	33a	Billing provider NPI	If the rendering provider is affiliated with a group, you must enter the group practice's *organization (type 2)* NPI.
2310A	NM109	17b	Referring provider NPI	The referring/ordering provider's NPI is required for lab, DME, and radiology claims, and also for opioid treatment program services.
2310B	NM109	24j	Rendering provider NPI	The rendering provider's individual (type 1) NPI is required when the *billing* provider or organization (type 2) NPI ***is not the same*** as the rendering provider's NPI.
2010AA	REF*EI	25	Federal tax ID	Prior to submitting claims, the federal tax ID must be on file with AZ Blue for *all* providers billing under it. If a provider is not updated in our system with this tax ID, claims may be processed as out-of-network, causing unnecessary delays and adjustments.

Geographic location

When services are provided or performed in Arizona for BCBS members, submit the claim to AZ Blue except for:

- Claims for the ACA StandardHealth with Health Choice plan-prefix IAZ (see page 19-6)
- Certain chiropractic claims (see page 19-10)
- Workers' compensation claims (see Section 8)
- Certain air ambulance claims (see page 19-7)
- Certain ancillary claims (see page 19-12)
- Medicare Advantage claims for plans administered by Optum Health Network Arizona or Arizona Priority Care (see page 19-15)

Claim Submission Requirements

Providers who render services to AZ Blue members outside of Arizona must submit claims to the Blue Plan in that service area. The BlueCard® program allows members to obtain medical services while traveling or living in another Blue Plan's service area (see Section 9 for more information).

Providers who are contracted with AZ Blue but provide services at physical locations outside of Arizona must submit those claims to the Blue Plan in that service area. These claims will be treated as out-of-network claims if the provider is not also contracted with the local Blue Plan.

Submitting institutional claims – interim bills

The following requirements apply for submission of claims for interim bills:

- **Acute care hospitals** that are reimbursed an MS-DRG payment for an inpatient stay may not submit interim bills. These claims will be returned to the provider. The MS-DRG will be assigned based on the diagnosis code at the time of discharge.
- **Skilled nursing facilities** that are reimbursed a per diem payment for an inpatient stay may submit interim bills.
- **Outpatient interim bills** – Type-of-bill frequency codes ending in 2, 3, or 4 may not be submitted. Outpatient services, even for the same course of treatment, should be submitted as separate, recurring services and not as an interim bill that is interrelated to other claims (e.g., therapy services, home health).

Submitting COB claims with another carrier's information

When a patient is covered by two or more health insurance plans, include all other party liability (OPL) value codes, group adjustment codes, reason codes, and amounts shown on the primary payer remittance notice.

The following tables show where COB values should be populated in a HIPAA 837 transaction.

Bill ***medical and outpatient claims*** with service line detail from the primary carrier:

REQUIRED LOOPS	REQUIRED SEGMENTS
Loop 2320	SBR*P AMT*D AMT*EAF OI* MOA
Loop 2330A	NM1*IL N3 N4
Loop 2330B	NM1*PR N3 N4 REF*F8 (COBA)
Loop 2430	SVD**Other Payer Identifier CAS*CO CAS*PR DTP*573

See HIPAA TR3 for required/situational rules for secondary payer.

Bill ***inpatient facility claims*** at a claim level (service line detail is not required):

REQUIRED LOOPS	REQUIRED SEGMENTS
Loop 2320	SBR*P CAS*CO CAS*PR AMT*D AMT*EAF OI* MIA
Loop 2330A	NM1*IL N3 N4
Loop 2330B	NM1*PR N3 N4 DTP*573 REF*F8 (COBA)

See HIPAA TR3 for required/situational rules for secondary payer.

Claim Submission Requirements

Claim resubmission guidelines to reduce unnecessary duplicate claims

Before resubmitting a claim, *always* check the status of the previously submitted claim and ensure your clearinghouse does the same.

Follow these steps:

1. Check claim status through a 276/277 electronic transaction, an inquiry using claim status tools on the Availity Essentials or AZ Blue provider portal, or by calling the automated interactive voice response (IVR) system at 1-844-995-2583 (for Medicare Advantage, call 1-800-446-8331).
2. Instruct your clearinghouse *not* to automatically resubmit claims. Do not submit a new claim for the same service until you have checked the status of the original claim and verified that it's not on file with us.

   Note: Our timely filing policies and proof of timely filing also apply to claim resubmissions (see Timely Filing on page 19-1).
3. Only after you or your clearinghouse verifies that a claim is not on file, resubmit the original claim. Do not put any notes or marks on resubmitted claims. Our automated scanning systems cannot read notes such as "tracer claim," "duplicate claim," or other similar comments, as well as highlighted text, stamps, and stickers. This will delay claim processing or result in the claim being returned to you.
4. If you have changes to a previously submitted claim, follow the guidelines on page 19-19 to make an adjustment request.

Claim action scenarios (What do I do when … ?)

Here are some common claim situations and the action you need to take:

SITUATION	SUBMIT NEW "CLEAN" CLAIM	RE-SUBMIT CLAIM	REQUEST CLAIM ADJUSTMENT	SUBMIT PROVIDER GRIEVANCE (FOR MEDICARE ADVANTAGE, REQUEST CLAIM RECONSIDERATION)
1. You are submitting a claim for the first time.	✓			
2. The claim you submitted was rejected (not processed) and returned with a letter indicating that required valid information was missing.	✓			
3. You did not receive acknowledgment of a claim you submitted. You have checked status of the original claim and verified with your clearinghouse that the claim is not on file.		✓		
4. The claim was processed, but you need to adjust or change some information.			✓	
5. The claim was denied as not a covered benefit because an incorrect diagnosis was billed. You want to correct a code.			✓	
6. The claim was processed, but you need to change or add a modifier.			✓	
7. You have validated that the information on the claim is correct, but you disagree with and want to challenge a claim processing decision.				✓

Claim Submission Requirements

Submitting requested medical records for claim adjudication

We sometimes require medical records to determine benefits related to your claim. Records requests might come from AZ Blue or our delegated entities such as eviCore or Episource, or from other Blue Plans.

We might also require records from you to process a claim from a different provider. For example, we might require medical record information from a member's primary care provider to determine coverage for a hospital or lab claim related to the PCP's diagnosis. In this situation, the PCP's claim might have already been processed, but the PCP's records are still essential to determining whether the hospital or lab services are covered. The servicing provider's claim could be denied for lack of medical records.

Providers must submit requested records promptly so that claims, including those of other providers, can be processed timely. When you receive a request for records, you must respond within the time frame indicated in the notice (typically within 10 business days). Follow the instructions in the notice and include a copy of the notice (often the notice has a barcode identifier that we need to match your records to the claim).

Note: For CHS group claims, **submit medical records directly to the requesting TPA**, *not* to AZ Blue.

For information about requesting a claim adjustment, see page 19-19. For information about submitting a provider grievance or a Medicare Advantage claim reconsideration request, see Section 22.

ACA StandardHealth with Health Choice Plan

AZ Blue offers a PCP-HMO benefit plan that uses the ACA Health Choice network. You can identify members with this plan by the following information on the ID card:

- Plan name: **ACA StandardHealth with Health Choice**
- Network name: **ACA Health Choice**
- Member ID prefix: **IAZ**

Submit claims to EDI payer ID RP105

Claims for members with this plan should be submitted to EDI payer ID **RP105**. Specialists must include PCP referral information on claims. The ACA StandardHealth with Health Choice team will also be handling eligibility, benefits, prior authorization, claim status, remits, and appeals and grievances for this plan.

For more information, visit azblue.com/aca-standardhealth-health-choice or call 1-800-322-8670.

Air Ambulance Services Claims

Submitting claims for air ambulance services

Claims for air ambulance services must be filed with the Blue Plan in whose service area the point-of-pickup ZIP code is located.

AIR AMBULANCE	REQUIRED CLAIM DATA	WHERE TO FILE	EXAMPLES
Air ambulance transport services	Point-of-pickup ZIP code: On the 837P electronic submission: Populate the origin information (ZIP code of the point of pick up) in the Ambulance Pick Up Location Loop. On the 837I electronic submission: For air ambulance service not included with local hospital charges, populate the origin information (ZIP code of the point of pickup) in the Value Information Segment. On the CMS 1500: Populate field 23 with the 5-digit ZIP code of the point of pickup. If applicable, the EMG field should be indicated. On the CMS-1450 (UB-04): For air ambulance service not included with local hospital charges, populate Form Locators 39-41 with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved code and value specified by the National Uniform Billing Committee (NUBC) in the UB-04 Data Specifications Manual. • Form Locators: (FL) 39-41 • Code: A0 (Special ZIP code reporting) or its successor code specified by the NUBC • Value: Five-digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance	Submit the claim to: Submit the claim to the Plan in whose service area the point-of-pickup ZIP code is located (except when the pickup location is outside of the U.S.). If you contract with multiple Blue Plans that overlap service areas in the point-of-pickup ZIP code, you may file the claim with any of those Plans. When a member's pickup location is outside of the U.S., file the claim with Blue Cross Blue Shield Global Core at bcbsglobalcore.com or claims@bcbsaglobalcore.com, or mail to: Service Center, P.O. Box 2048, Southeastern, PA 19399.	A. The AZ Blue member is picked up in ZIP code 85021 (Phoenix, AZ). *Submit the claim to* AZ Blue (EDI payer ID 53589). B. The AZ Blue member is picked up in ZIP code 68107 (Omaha, NE). *Submit the claim to* Blue Cross Blue Shield of Nebraska. C. The AZ Blue member is picked up in Mexico. *Submit the claim to* Blue Cross Blue Shield Global Core.

- The air ambulance claim-filing rules apply regardless of the provider's contracting status with the Blue Plan in the service area where the claim is filed. The rules apply across all lines of business.
- When possible, providers are encouraged to verify member eligibility and benefits by calling the phone number on the back of the member ID card.
- Out-of-network air ambulance services are in-scope for the No Surprises Act (NSA) patient billing protections.

Note: Members are financially liable for air ambulance services not covered under their benefit plan. Most plans do not cover non-emergency air ambulance services and some plans (including all Medicare plans) do not have coverage outside of the United States. For requirements for billing members for non-covered services, see Section 17.

Blue Plan Secondary to Medicare Claims (Crossover Process)

Submitting claims when Medicare is primary and a Blue Plan is secondary
For members with Original (Traditional) Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary or Medicare carrier. Once you have submitted your claim, *wait* to receive the Medicare remittance advice (MRA) from Medicare before taking further action.

- Be sure to enter the correct Blue Plan name as the secondary carrier to avoid errors in the crossover process.
- Include the member ID prefix on your claim—this is critical for confirming Blue membership and coverage, and for facilitating prompt payment.
- In some cases, the member ID card contains a COBA-ID number. If so, be sure to include that number on your claim.

When you receive the Medicare Remittance Advice (MRA) from Medicare, check to see if Medicare has automatically forwarded (crossed over) your claim to the Blue Plan. The MRA will clearly indicate whether the claim has been crossed over for secondary processing. Here are the **next steps:**

- **If the MRA indicates your claim was forwarded:**
  If the MRA indicates that the claim was crossed over, it means that Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and that the claim is in the process of being adjudicated for you. *DO NOT resubmit the claim to us.* Duplicate claims result in processing and payment delays.
  - The MRA may include a "remark Code MA 18" stating: "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them."
  - Any Medicare primary claims submitted directly to AZ Blue within 30 days of the date when the MRA indicates the claim was crossed over will be returned. This allows us to process the Medicare crossover claim when we receive it and avoid duplicate claims.
- **If the MRA indicates your claim was not forwarded:**
  If the MRA indicates that the claim was *not* crossed over, submit the claim to us.

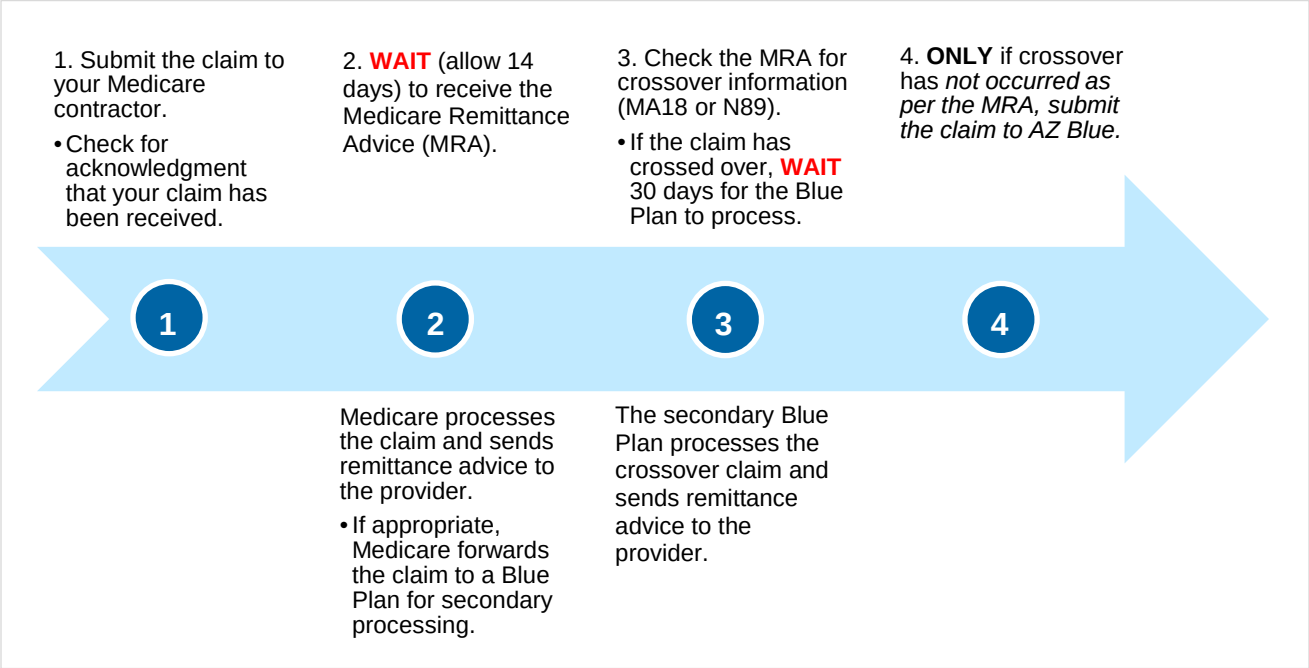
  Submit the claim electronically and include all other party liability (OPL) value codes, group adjustment codes, reason codes, and amounts shown on the MRA. There should not be any conversions between the OPL values and group adjustment/reason codes. Please send information exactly as listed on the MRA.

Summary

- Submit Medicare-related claims to the Medicare contractor and then *wait to receive the MRA* from Medicare before taking any further action.
- Do not submit Medicare-related claims simultaneously to Medicare and AZ Blue. We will reject Medicare primary claims submitted within 15 days of the discharge/final date of service on the claim and request the primary carrier payment information.
- If the MRA indicates that Medicare has sent a crossover claim to the member's home Blue Plan, do *not* submit the claim to us within 30 days of the crossover date indicated on the MRA.
- When submitting for secondary payment, ensure that the billing charges match exactly what is displayed on the MRA.

Blue Plan Secondary to Medicare Claims (Crossover Process)

Medicare crossover process and timeline



Chiropractic Services Claims

Claims for chiropractic services should be sent either to ASH or to AZ Blue.

SEND TO ASH (EDI # ASH01):

1. **Claims for most AZ Blue commercial members**
   For most AZ Blue commercial members, submit claims for chiropractic services directly to American Specialty Health (ASH) via ASHlink.com, an approved clearinghouse, or on a CMS 1500 claim form.

   Exception: AZ Blue administers chiropractic claims for some employer group plans and this is indicated when you verify eligibility and benefits on ASHlink.com. For those members, send claims to AZ Blue using EDI payer ID **53589**.

2. **Claims for all Medicare Advantage (MA) members**
   We contract with ASH to process claims for all of our MA plans. Submit claims for chiropractic services directly to ASH via ASHlink.com, an approved clearinghouse, or on a CMS 1500 claim form.

SEND TO AZ BLUE (EDI # 53589):

1. **Claims for CHS members**
   For CHS group members, chiropractic utilization management is performed by the third-party administrator (TPA) or the group's designee. However, we make the ASH network available to those members and perform the claim pricing before forwarding to the TPA. Send CHS claims for chiropractic services directly to us.

2. **Claims for FEP and BlueCard (out-of-area)**
   For FEP members and members of other Blue Plans who receive services through the BlueCard program, the ASH network is the exclusive network for chiropractic services. However, AZ Blue adjudicates all claims for these members. Send FEP and BlueCard claims for chiropractic services directly to us for processing.

ASH is a separate, independent company, contracted with AZ Blue to provide the chiropractic network, covered chiropractic services, and related claim processing and appeal/grievance resolution.

Corporate Health Services (CHS) Group Claims

Submit Corporate Health Services (CHS) claims to AZ Blue for pricing

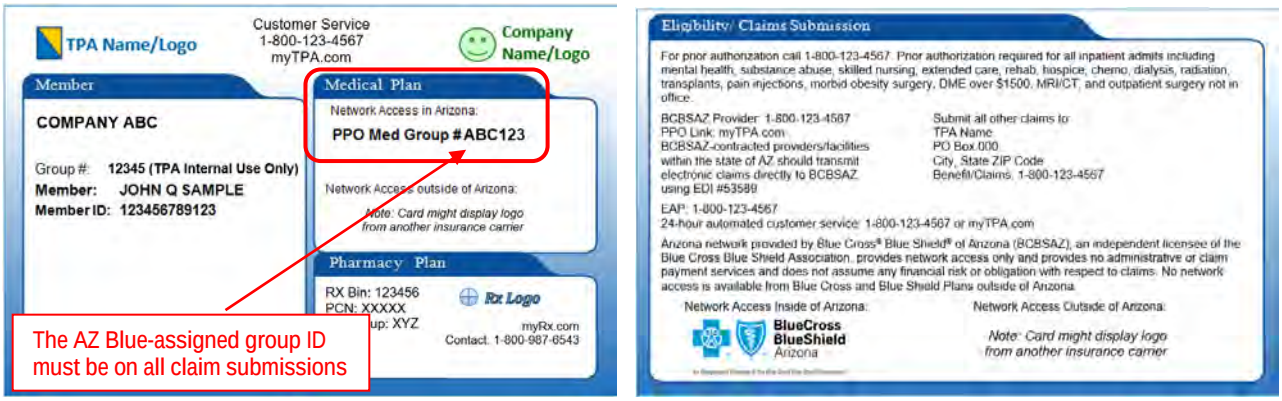
Submit all CHS claims electronically to AZ Blue using EDI payer ID 53589. This includes claim adjustment requests (see page 19-19). We will price your claims (and adjustments) and then forward them to the group's third-party administrator (TPA). *Do not send claims directly to the TPA.*

Use the AZ Blue-assigned group ID number on all CHS claims

All CHS claims and claim adjustment requests must be submitted electronically using the correct AZ Blue-assigned group number. This ID number is displayed on the front of the member ID card and includes three letters followed by three numbers (e.g., ABC123) – see sample below.

Entering an incorrect group number on a claim can cause considerable delay and a reportable PHI breach. For more information, see Section 8.

This sample ID card shows the AZ Blue-assigned group ID for Arizona network access. Note: The design of CHS group cards varies by employer/TPA and may include a group number that is for TPA internal use only. Do *not* use the internal group number on your claims.



Set up the group's TPA as the payer in your system

The TPA adjudicates your claims and is your point of contact for claim status and all other functions (except claim pricing). Your reimbursement and remit statements come from the TPA, not AZ Blue.

How to identify the group's TPA

Check the member ID card for the group's TPA. Often, the TPA's logo is on the front of the card, in the upper left corner. The AZ Blue logo is on the back of the card. CHS group and TPA information is also available via the AZ Blue provider portal at "Practice Management > Eligibility and Benefits > CHS Group Information." The CHS Group/TPA Information page includes a PDF list with specific information, including:

- Group name
- AZ Blue-assigned group number (three letters followed by three numbers: ABC123)
- Name of the TPA or group processing the claims
- Name of the utilization management vendor handling prior authorization

For more information about CHS group plans, see Section 8.

Lab, DME, Specialty Pharmacy, and Home Infusion Therapy Claims

How to submit claims for lab, DME, specialty pharmacy, and home infusion services
Ancillary claims for all members except those with Federal Employee Program (FEP) and CHS plans must follow these Blue Plan claim filing rules (see next page for examples):

- **Independent clinical laboratory providers:** Submit claims to the Blue Plan where the referring or ordering provider is located per that provider's listed physical address in the NPI/NPPES Registry.
- **Durable medical equipment and supplies providers:** Submit claims to the Blue Plan that services the location to which the equipment was shipped or the location of the retail store where the equipment was purchased. Visit the BCBS Companies page for a list of Blue Plans by location.
- **Specialty pharmacy (for medical benefits) providers:** Submit claims to the Blue Plan where the *ordering provider* is located per that provider's listed physical address in the NPI/NPPES Registry.
- **Home infusion therapy (HIT) providers:** Submit claims to the Blue Plan in the service area where the treatment was rendered.

  Note: To be considered in network, HIT providers must be contracted with the Blue Plan in the service area where the treatment was rendered.

If a provider is contracted with multiple Blue Plans in the same service area for the same product type (e.g., PPO or Traditional), the claim may be filed with any of those Blue Plans.

Please note: *Claims submitted to AZ Blue incorrectly* ***will be returned to the provider*** *for correct Blue Plan submission.*

Exceptions to the Blue Plan ancillary claim filing rules
Blue Plan ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan in the service area where the claim is filed. However, the rules do not apply to all lines of business.

Exceptions:

1. FEP plans (member ID prefix R): Use the following guidelines for ancillary claim filing.
   - Labs: Submit claims to the Blue Plan where the lab services were rendered.
   - DME: Submit claims to the Blue Plan where the DME provider is located.
   - Specialty Pharmacy: Submit claims to the Blue Plan where the Specialty Pharmacy is located.
   - HIT: Submit claims to the Blue Plan in the service area where the treatment was rendered.
2. CHS group plans (no member ID prefix): Submit claims directly to AZ Blue (EDI payer ID 53589) for pricing. Then we will forward your claim to the group's TPA.

Remember to verify member eligibility and benefits before providing any ancillary service. If you have any questions about where to file a claim, contact your Provider Relations Contact or call Provider Assistance at 1-844-995-2583.

Lab, DME, Specialty Pharmacy, and Home Infusion Therapy Claims

Ancillary claim filing examples

INDEPENDENT CLINICAL LAB	REQUIRED CLAIM DATA	WHERE TO FILE	EXAMPLE
Any type of non-hospital-based laboratory: Types of service include, but are not limited to, blood and urine sample analysis.	Referring or Ordering Provider: On the 837P Professional Electronic Submission: Loop 2420E for Ordering Provider; 2310A for Referring Provider (both at the claim level). On the CMS 1500: Field 17 (left of the dotted line); enter DK for Ordering Provider or DN for Referring Provider.	Submit the claim to: The Blue Plan where the ***referring or ordering provider is located, per their NPI/NPPES Registry.*** Note: • Claim must be processed based on information submitted on the claim. • The referring provider NPI, as submitted on the claim, must be used to determine where service was rendered. • Claims for lab analysis must be submitted to the Blue Plan in whose service area the referring provider is located. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.	Blood is drawn in a lab or office setting located in Arizona. The ordering provider is located in Arizona. Blood analysis is done in New Mexico. *Submit claim to* AZ Blue (EDI payer ID 53589).

DME	REQUIRED CLAIM DATA	WHERE TO FILE	EXAMPLES
Durable/home medical equipment supplier: Types of service include, but are not limited to, hospital beds, oxygen tanks, and crutches.	Patient's Address: • On the 837P Professional Electronic Submission: Loop 2010CA. • On the CMS 1500: Field 5. Referring or Ordering Provider: • On the 837P Professional Electronic Submission: Loop 2420E for Ordering Provider; 2310A for Referring Provider (both at the claim level). • On the CMS 1500: Field 17 (left of the dotted line); enter DK for Ordering Provider or DN for Referring Provider. Place of Service: • On the 837P Professional Electronic Submission: Loop 2300, CLM05-1. • On the CMS 1500: Field 24B. Service Facility Location Information: • On the 837P Professional Electronic Submission: Loop 2310C (claim level). • On the CMS 1500: Field 32.	Submit the claim to: The Blue Plan where the equipment was ***shipped to or purchased in a retail store.***	A. Wheelchair is purchased at a retail store in Arizona. *Submit claim to* AZ Blue (EDI payer ID 53589) B. Wheelchair is purchased on the internet from an online retail supplier in Florida and shipped to Arizona. *Submit claim to* AZ Blue (EDI payer ID 53589). C. Wheelchair is purchased at a retail store in Arizona and shipped to Florida. *Submit claim to* Florida Blue.

Lab, DME, Specialty Pharmacy, and Home Infusion Therapy Claims

SPECIALTY PHARMACY	REQUIRED CLAIM DATA	WHERE TO FILE	EXAMPLE
Specialty pharmacy: Types of service: Non-routine biological therapeutics ordered by a healthcare professional as a covered medical benefit, as defined by the member's Plan's Specialty Pharmacy formulary Includes, but is not limited to, injectables and infusion therapies.	Ordering Provider: • On the 837P Professional Electronic Submission: Loop 2420E for Ordering Provider (at the claim level). • On the CMS 1500: Field 17 (left of the dotted line); enter DK for Ordering Provider.	Submit the claim to: The Blue Plan where the *ordering provider is located, per their NPI/NPPES Registry.*	Patient is seen by a provider in Arizona who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in Montana, where the member lives for 6 months of the year. *Submit claim to* AZ Blue (EDI payer ID 53589).

HOME INFUSION THERAPY	HOW TO FILE (REQUIRED DATA)	WHERE TO FILE	EXAMPLE
HIT provider: Type of service includes, but is not limited to, individualized, medically necessary, intravenous medication infusion in the patient's place of residence or an ambulatory infusion center (AIC).	Place of service: • On the 837P Professional Electronic Submission: Loop 2300, CLM05-1. • On the CMS 1500: Field 24B. Referring or ordering provider (required for the purpose of directing any medical records requests): • On the 837P Professional Electronic Submission: Loop 2420E for Ordering Provider or 2310A for Referring Provider (both at the claim level). • On the CMS 1500, field 17 (left of the dotted line), enter DK for Ordering Provider or DN for Referring Provider.	Submit the claim to: The Blue Plan in the service area where the infusion treatment was rendered.	Patient begins infusion therapy in California, and then travels to Arizona to stay with family members for a few months. HIT company sends a healthcare professional to continue the member's infusion therapy in the Arizona family residence. *Submit the claim to* AZ Blue (EDI payer ID 53589).

Help members avoid higher cost: Refer to in-network ancillary providers
When you use outside vendors to provide services (e.g., sending a blood specimen for special analysis that cannot be done by the lab where the specimen was drawn), please use ancillary providers that are in-network for the member's benefit plan. This reduces the possibility of additional member liability for covered benefits.

You can find in-network providers in the **Find a Doctor** provider directory at azblue.com/directory. If the service can't be provided by an in-network provider, prior authorization must be obtained for the out-of-network services.

Members are financially liable for ancillary services not covered under their benefit plan. Providers must request payment directly from the member for non-covered services.

Claims for covered services provided by out-of-network, **out-of-state** DME, clinical laboratory, HIT, and specialty pharmacy providers will be processed as follows:

- Most PPO benefit plans will pay the fee-for-service (FFS) out-of-network allowed amount (rather than the billed amount), resulting in greater out-of-pocket costs to the member.
- Most HMO benefit plans do not have an out-of-network benefit (except for emergent/urgent services). The claim will be denied, and the member will be responsible for the entire billed amount on the claim.

Medicare Advantage Claims

AZ Blue partners with Optum Health Network (OHNAZ) Arizona and Arizona Priority Care (AZPC) to provide utilization management and claim/payment services for a subset of our Medicare Advantage (MA) HMO membership. Members with these delegated functions can be identified by the claim filing information on the back of the ID card. All other MA plans are administered by AZ Blue.

Submitting Medicare Advantage claims

Except for the types of services described below the table and on the next page, this table shows where to submit claims, according to the member's specific plan and service area. Check the back of the member ID card to see if the claims should be filed with AZ Blue (BCBSAZ), Optum Health Network Arizona (OHNAZ), or Arizona Priority Care (AZPC).

NETWORK	BENEFIT PLAN	PREFIX	SERVICE AREA	CLAIM ADMINISTRATOR
Blue Advantage Network	Blue Best Life Classic H0302-006	M2K	Maricopa and Pinal counties	*Check the member ID card back for the administrator's claim filing/payment information.* AZ Blue (BCBSAZ) EDI: 53589 P.O. Box 29234; Phoenix, AZ 85038-9234 Optum Health Network Arizona (OHNAZ) EDI: LIFE1 P.O. Box 30539; Salt Lake City, UT 84130 Arizona Priority Care (AZPC) EDI: 27154 585 N Jupiter Dr #150; Chandler, AZ 85266
	Blue Best Life Plus H0302-001			
	Blue Best Life Classic H0302-008	M2K	Pima County	AZ Blue (BCBSAZ) EDI: 53589 P.O. Box 29234; Phoenix, AZ 85038-9234 Optum Health Network Arizona (OHNAZ) EDI: LIFE1 P.O. Box 30539; Salt Lake City, UT 84130
BlueJourney PPO Network	Supports out-of-area Medicare Advantage PPO group plans issued by other Blue Plans (various prefixes), for members visiting or living in Arizona			AZ Blue (BCBSAZ) EDI: 53589 P.O. Box 29234; Phoenix, AZ 85038-9234

ADDITIONAL CLAIM SUBMISSION INFORMATION FOR ALL MA PLANS	
Musculoskeletal Network–American Specialty Health (ASH)	American Specialty Health (EDI payer ID ASH01)
Davis Vision Network	Davis Vision (EDI payer ID 00157)
BlueDental Prime Network for Medicare Advantage	AZ Blue (EDI payer ID 53589) P.O. Box 211424; Eagan, MN 55121

Claims related to Medicare-covered hospice services: Submit to CMS

An AZ Blue MA member who has six months or less to live has the right to elect hospice. We will provide a list of Medicare-approved hospices in the member's geographic area.

If an AZ Blue MA member elects hospice but continues to pay applicable premiums, the MA coverage remains active, and the member may still obtain all medically necessary services and supplemental benefits offered by the plan.

Medicare Advantage Claims

The hospice will provide treatment related to the member's condition. The member stays enrolled in the MA plan for other covered services not related to hospice care.

CMS becomes the primary payer for all Medicare-covered hospice services. Hospice is responsible for providing, arranging, and paying for all palliative care, including prescribed drugs, except in certain limited circumstances. Claims for hospice services must be sent directly to CMS.

Claims related to clinical trials: Submit to Original Medicare
Coverage for clinical trials is the responsibility of Original Medicare. All claims related to clinical trial charges should be submitted to Original Medicare, following the CMS claim submission guidelines for these services. Following the Medicare determination, the claim may be submitted to AZ Blue for consideration of any additional benefits. Be sure to include the assigned Clinical Trial (CT) number when you submit the claim to AZ Blue (use Loop 2300, REF02, REF01=P4).

Claims related to transplant services: Submit to Optum (EDI payer ID 41194)
We have contracted with Optum to price claims related to transplant services. All claims related to covered transplant service should be submitted to Optum directly at EDI payer ID 41194. Optum then forwards the priced claims to AZ Blue for adjudication.

Submitting ASC claims
For MA member plans, freestanding surgery center facilities must submit claims via an 837P, per CMS Medicare Advantage guidelines.

Submit paper claims *only* if you are unable to submit electronically

AZ Blue P.O. Box 29234 Phoenix, AZ 85038-9234	Optum Health Network Arizona P.O. Box 30539 Salt Lake City, UT 84130	Arizona Priority Care Attn: Claims Department 585 N Jupiter Dr, Ste 200 Chandler, AZ 85226

Make sure your printed data is properly aligned within the lines and is dark enough to be readable by OCR imaging technology. Use only black ink. Our automated systems cannot read claims if the print is too light or in dot matrix. Claims that cannot be read will be returned.

Claim reconsideration requests
MA claim payment disputes are resolved through the claim reconsideration process. For more information, see Section 22.

Encounter data reporting
AZ Blue requires all Medicare Advantage network providers to submit encounter data regardless of the reimbursement methodology. Encounter data is defined by CMS as all data necessary to characterize the content and purpose of each encounter between a member and a provider or supplier. Billed charges should always be reflected on the claim form.

Risk adjustment, documentation, and coding
Risk adjustment was mandated by the Balanced Budget Act of 1997. The methodology requires the collection of data reported through claims/encounter data for services provided in the current year. This helps establish cost of patient care and determine resources needed for the next year.

CMS chose a risk model based on measuring chronic conditions; the more chronic conditions a patient has, the more care they may require. Each patient is assigned a risk adjustment factor (RAF), which is a numeric value assigned by CMS to identify the health status of the patient.

Medicare Advantage Claims

The risk model includes:

- Criteria for age/sex
- Additional risk factors for Medicaid status or if the patient was eligible for Medicare due to a disability
- A RAF for the total of all chronic conditions

Health status is one of the primary factors of CMS reimbursement. Each year, providers must assess, address, and document all chronic conditions in the medical record for all MA patients. Proper documentation and coding of these chronic diseases can help ensure that RAF scores accurately reflect the health status of your patients. If the condition is not documented, it cannot be coded and if it cannot be coded, it cannot be reported. In addition, coding must be at the highest level of specificity. Accuracy is essential.

Claim Status Inquiries

Tracking and balancing your claims

When you submit your claims electronically, you can use the 999 and 277CA acknowledgement reports to track the receipt of the claims and see if any of them had errors. The custom claims acknowledgment report (CCAR) summary offers you a way to balance your claims with more detailed information. The CCAR lists the accepted claims, identifies claims with errors, and shows the reasons for the errors. You can use this report as proof of timely filing.

For more information about the electronic reports, view or download our Claims e-learning PDF in the AZ Blue provider portal at "Education and Training > Webinars and E-learning > Provider E-learning > Claims." If you have questions, you can access the HIPAA Transaction Standard-AZ Blue Companion Guide via our Claims and Remits page under Claim Submission and Adjustments.

How to check claim status:

- HIPAA transactions 276/277 (inquiry/response) – real-time or batch
- Online claim status tools

  AZ Blue, FEP, and BlueCard (out-of-area) claims, check claim status via the AZ Blue or Availity Essentials provider portal (will include up to three years history).

  - ACA StandardHealth with Health Choice plan, use azblue.com/aca-standardhealth-health-choice

  CHS group claim status, contact the group's TPA

  AZ Blue Medicare Advantage claim status:

  - AZ Blue (azbluemedicare.com/login) or the Availity Essentials portal
  - Optum Health Network Arizona (OHNAZ): optumproportal.com/home
  - Arizona Priority Care (AZPC): azprioritycare.com/for-providers
- Phone

  AZ Blue Provider Assistance team: 1-844-995-2583

  - ACA StandardHealth with Health Choice team: 1-800-322-8670

  AZ Blue Medicare Advantage team: 1-800-446-8331

  - Optum Health Network Arizona (OHNAZ): 1-877-370-2845
  - Arizona Priority Care (AZPC): 480-499-8720

  CHS Groups: Contact the group's TPA

  BlueCard (Out-of-Area Plans) team: 602-864-4114 / 1-800-441-0483

Response time on electronic transactions

Blue Plans must be available to respond to internet or real-time HIPAA transaction inquiries Monday through Saturday, between 12 a.m. and 11:59 p.m. Central Time, except for scheduled maintenance times and six national holidays. Some Blue Plans respond to electronic inquiries 24/7.

AZ Blue responds to electronic inquiries 24 hours a day, Monday through Saturday, except holidays. Most maintenance down time happens on Sundays, but there are occasional maintenance periods on Fridays and Saturdays as needed.

Claim Adjustments

Occasionally, you might need to correct or change information on a claim after it has been processed because the original claim information was wrong or incomplete. You must submit corrections via an 837 electronic adjustment request, using the same claim type as the original (837P, 837I, 837D). If you are changing the claim type, you must submit a new, clean claim. We typically return paper claim corrections except when the correction is for an NPI change (see more information below).

Your adjustment request must include the resubmitted claim (all lines) with corrections, frequency code 7, and the correct original claim ID (this is a character value that must include any leading zeros) in the appropriate EDI loop. For institutional claims, we need admission through discharge information.

- We will do a line-by-line comparison of the adjustment to the original claim.
- The adjustment will be returned if the claim information is incomplete or if frequency code 7 is missing.
- If you want to completely void or cancel the original claim and start over with a new clean claim, use frequency code 8.

When to submit an adjustment

Claim adjustments can *only* be made **after the claim is fully adjudicated** and the remit is available. AZ Blue will reject any adjustments sent before the claim is finalized.

Most claim adjustments must be made within one year from the date the claim was originally processed. Adjustments beyond the one-year period are allowed in the limited circumstances listed in the provider participation agreement, including:

- Claims for services rendered to an FEP member
- Claims involving subrogation and coordination of benefits with Medicare or another private payer (including self-funded employer groups) not governed by state law
- Claims involving “fraud,” which means, without limitation, a claim that includes or is based on a willful misstatement or omission of material fact by a member or provider, resulting in incorrect adjudication of a claim, and includes, without limitation, failure to disclose other applicable coverage, use of CPT® codes that do not accurately reflect services provided, billing for services not rendered, and billing for services under the name of a provider other than the provider who actually rendered the service
- Claims for which a longer period of time is required by applicable state or federal law, including, without limitation, adjustments required because of federally mandated changes in Medicare reimbursement rates, federal requirements that certain government payers be secondary payer or payer of last resort, and federal laws prohibiting providers from accepting more than the Medicare limiting charge
- Claims for which AZ Blue is under a lawful order to adjust a claim because a member or provider has prevailed on a healthcare appeal
- Claims under a workers’ compensation policy

Process date

The process date is the date on which a claim is adjudicated or finalized in our claim processing system. When a claim is adjusted or re-adjudicated, we assign a new process date, and the claim is subject to the current AZ Blue pricing logic.

Claim Adjustments

No claim corrections are permitted once a grievance or appeal is filed
Before submitting a grievance related to a claim, ensure that all information on the claim is accurate. A claim may not be corrected after a grievance or appeal has been filed. Grievances and appeals are carefully reviewed and decisions are based on the premise that all information on the claim is accurate.

Submitting 837 adjustment requests
Do *not* send medical records with the initial adjustment request. If we need records to support a correction, we will request them later. Types of claim information corrections that may be submitted via an 837 adjustment include:

- Patient name
- Place of service
- Date of service
- Billed charge amount
- Member ID
- Number of units
- Other billing
- Anesthesia time
- Adding or changing modifiers
- Change in sequence of diagnosis codes
- Late charges to inpatient or outpatient claims
- Other insurance carrier COB payment

For more details on the submission of electronic adjustments, view or download the Electronic Claim Adjustments – User Guide, available via our Electronic Business page.

AZ Blue plan secondary to Medicare – claim adjustments
For members with Medicare primary coverage and AZ Blue secondary coverage (Medicare Supplement or other applicable AZ Blue plan), submit claim adjustments to the Medicare contractor first.

Workers' compensation (WC) – claim adjustments
For specific procedures to request adjustments to WC claims, see Section 8.

Correcting a provider NPI
If you are correcting a provider NPI, you must use our corrected claim form for each claim that is submitted for adjustment (not an electronic adjustment). To correct an NPI, you must include medical record documentation verifying the rendering provider. The fillable PDF form is available via our Forms page under Claims.

Limitation on the number of adjustments
You are responsible for the completeness and accuracy of submitted claims. We may refuse to accept an adjustment if you have submitted multiple adjustments of the same claim or altered medical records.

Include frequency code 7 or 8 for electronic adjustments
Submit the *entire* claim (for institutional claims, include admission through discharge) electronically as an adjustment, using frequency code 7 to indicate replacement of a prior claim. Without that code, we cannot verify that the request is for a claim adjustment, which could cause the claim to deny as a duplicate claim.

- If you want to completely void or cancel the original claim and start over with a new clean claim, use frequency code 8.
- We will return adjustment requests submitted with incomplete claim information or without frequency code 7 or 8.

Claim Adjustments

The following table shows conditions that must be met for 837 claim adjustments to be processed quickly and accurately:

ASC_X12N/005010X222_A1/E1 ASC X12 Standards for Electronic Data Interchange Technical Report Type 3								
TR3 Page #			Loop ID	Reference	Name	Codes	Length	Notes/Comments
Professional	*Institutional*	*Dental*						
159	145	147	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	Must = 7 (replacement of prior claim) or 8 (void/cancel prior claim)
196	166	168		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	Insert “F8”
196	166	168		REF02 Claim Information	Reference Identification	AN	1/30	For AZ Blue Local, FEP (DOS before 8/6/22) CHS, and Medicare Advantage, ICN/DCN must be 15 numeric characters. For FEP (DOS on or after 8/6/22), ICN/DCN must be 12 numeric characters or 12 numeric with one or two alpha characters in the 13th/14th position. For BlueCard (out-of-area) commercial and Medicare Advantage, ICN/DCN must be 15-17 numeric characters.

Notes:

- For NTE02 claim information, we no longer require the adjustment reason and narrative, except when you are submitting a correction to reduce line charges.
- For 837 institutional claim adjustments, we no longer require condition codes associated with adjustment (HI segment).
- Claims originally submitted with frequency code 5 (late charge[s] only) will continue to error.

Locum Tenens Providers

Providers are sometimes brought in to fill in for other providers on a temporary basis (e.g., to cover for sabbaticals, medical leaves, or other extended absences). A temporary provider is considered a "locum tenens" provider if any of the following criteria apply:

1. The provider plans to stay in the area for a limited time period.
2. The provider has malpractice insurance under the covering physician, or has insurance as the "additional insured" or "locum tenens" coverage.
3. The provider's state license indicates locum tenens.

Locum tenens providers are not contracted with AZ Blue
A locum tenens provider provides services only on behalf of another provider. The locum tenens provider is not eligible for credentialing with AZ Blue and will not be incorporated into our provider network database, claim processing system, or directory.

Billing for locum tenens providers
For services rendered by the covering locum tenens provider, bill us with the NPI number of the absent provider. List the locum tenens provider as the servicing provider and add "(Locum Tenens)" next to the name, or use modifier Q6. No direct billing is permitted by the locum tenens provider, and reimbursement will not be made directly to the locum tenens provider.

Note: Except in the limited, temporary locum tenens situations described above, no physician-level provider (which includes, but is not limited to, medical doctors, doctors of osteopathy, podiatrists, dentists, and chiropractors) may bill for services provided by another physician-level provider, or use another physician-level provider's NPI number.

"Incident To" Services and Pass-Through Billing

Non-physician providers who meet eligibility and credentialing criteria for a participation agreement are encouraged to be contracted directly with AZ Blue. It increases transparency and reduces confusion when patients see the name of the servicing provider on their explanation of benefits statement. Having a mid-level practitioner directly contracted with us can also be beneficial for a practice when the supervising provider is unavailable or out of the office for extended periods of time and the "incident to" billing requirements (see below) cannot be met.

Please note that we process claims based on the rendering provider. If the rendering provider is not contracted with us and is eligible for direct contracting (e.g., NPs, PAs, PTs, BCBAs), the claim will process as out-of-network (for PPO plans) or be denied (for HMO plans). To avoid this, be sure that any provider placed in the rendering field is contracted (if eligible, as described below).

"Incident to" services
"Incident to" billing is permitted for the following provider types who render services within the scope of their specialty training and licensing and bill under the supervising provider's name and NPI number:

- Non-physician providers with a credential that is *ineligible for an independent contract* with AZ Blue (including, but not limited to, clinical nurse specialists, physical or occupational therapy technicians, nutritionists, registered behavior technicians, licensed associate counselors, licensed associate marriage and family therapists, licensed associate substance abuse counselors, licensed master social workers)
- Non-physician providers who are eligible for an independent contract with AZ Blue, but are employed by a physician or practice and not practicing independently of the employment relationship

Example of "incident to" service
An example of a qualifying "incident to" service is when a physical therapist creates a treatment plan of covered services for a patient and assigns a physical therapist technician to carry out the plan or parts of it under the direct supervision of the physical therapist. The technician's services can be billed "incident to" using the therapist's name and NPI as the rendering provider.

Submitting claims with "incident to" billing
Submit the claim with the supervising provider's name and NPI number in the *rendering* provider fields. If the rendering provider field is blank, be sure to enter the supervising physician's NPI in the billing provider field (not the group organization NPI).

If the rendering provider is eligible, but not contracted directly with us, the service will be considered out-of-network and the patient may have considerable out-of-pocket costs.

"Incident to" billing requirements
We allow "incident to" billing only if the following conditions are met:

1. The covered services must be part of the patient's normal course of treatment, during which the supervising provider personally performed an initial service (for that condition) and remains actively involved in the management of the course of treatment.

   Exception: Certain licensing boards allow a supervised provider to perform the initial service and create the treatment plan when overseen by the supervising provider (e.g., associate counselors).

2. The covered services or supplies must be furnished as an integral part of the supervising provider's personal professional services in the course of diagnosis or treatment of an injury or illness.

3. The supervised practitioner must represent a direct financial expense to the supervising provider or the provider's group (such as a "W-2" or leased employee, or an independent contractor).
4. The supervising provider must directly oversee the subordinate practitioner and ensure that that person is acting within the scope of his or her training/certification, as applicable.
5. The supervising provider does not have to be physically present in the patient's treatment room while the services are provided but must be readily available to provide assistance and direction throughout the time the services are administered.
6. The patient record clearly documents satisfaction of all stipulations listed in requirements 1 and 2 above regarding the patient's care.

For homebound patients in medically underserved areas where there are limited healthcare providers, supervision may be more general for certain medical services (see CMPS Pub 100-02, Chapter 15, section 60.4 B). However, the supervising provider must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the services. All other "incident to" requirements must be met.

Another exception applies when the covered service provided at a patient's home is a one-time or intermittent service performed by personnel meeting pertinent state requirements (e.g., nurse, technician, behavioral health paraprofessional, or physician extender) and is an integral part of the physician's services to the patient.

Pass-through billing is prohibited
"Pass-through" billing occurs when a provider orders and bills for a service that is rendered by a different provider and does not qualify for "incident to" billing as described above. The rendering provider must bill us directly for the service unless we expressly approve a pass-through billing arrangement.

Example of prohibited pass-through billing
A doctor's office staff collects a lab specimen and alerts the lab to pick it up for processing. The doctor's office bills us for the lab processing services.

In the above scenario, the lab—not the doctor's office—performed the lab processing service. Therefore, the correct billing procedure is for the lab to submit a claim to us for the lab processing.

We will deny, or adjust and recover payment on, any claims that are identified as prohibited "pass-through" billing claims.

ADA Dental – Sample Claim Form (Version 2019)

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

837D (ADA 2019) Claim Data Overview and Detail

The HIPAA Transaction Standard – AZ Blue Companion Guide includes the AZ Blue-specific requirements for submitting 837D (dental) claim transactions. You can obtain the companion guide and testing requirements via our Electronic Business page.

Pages 19-27 through 19-31 list general guidelines and our required data elements for dental claims. **We return claims with missing or invalid data in required fields.** For more information and resources related to completing dental claims, you can visit the ADA website.

Include billing NPI and tax ID number on claims

We require your billing NPI and tax ID number (TIN) on all dental claims. Claims without this information will be rejected. If the treating provider is different from the billing provider, we also need the treating provider NPI.

The TIN and NPIs submitted on claims must match those on file for you in our claim system; otherwise, your claims will be returned. To avoid delays, use the Provider Information Change Form—Dental (located on our Forms page) to notify us of updates to your practice information.

Important: Solo practitioners (sole proprietors) must use the Billing Provider Entity Type Qualifier 1 (= person with name and individual NPI). Dental claims billed under a solo practitioner *should not* include the rendering provider loop 2310B.

Claim attachments for BlueDental plans

For BlueDental℠ stand-alone dental plans (prefixes 99D and MUM), we are unable to receive dental records electronically, except if your practice uses DentalXchange or Vyne Dental for electronic claim attachments. Be sure to enter the attachment reference number in the “Remarks” section (field 35) of your claim. This allows us to access the electronic attachments upon receipt of the claim.

If you are not using DentalXchange or Vyne Dental for electronic claim attachments and are billing for services that require documentation (e.g., radiographs, images, provider notes), submit claims using the ADA paper form to:

AZ Blue BlueDental Claims
P.O. Box 211424
Eagan, MN 55121

Special circumstances require use of CMS 1500 claim form

AZ Blue accepts the ADA Dental Claim Form for dental services covered under a member’s medical benefits (generally limited to services that are integral to medical care or for treatment of a dental accident). Some out-of-area Blue Plans will not accept dental claim forms for services covered by medical benefits. Instead, these claims will need to be submitted on a CMS 1500 (02/12) form using CPT® or CDT® codes. For assistance, contact your AZ Blue Provider Relations Contact.

837D (ADA 2019) Claim Data Overview and Detail

ADA Field	Loop	Element	Description	Special Instructions
Header Information : Claim Information				
1	2300 2400	REF SV111	Type of Transaction (mark all applicable boxes) ☐ Statement of Actual Services ☐ Request for Predetermination/ Preauthorization ☐ EPSDT/Title XIX	Check the "Statement of Actual Services" box for all claims submitted to AZ Blue. Predetermination requests are accepted for BlueDental stand-alone plans. Check the predetermination/preauthorization box.
2	2300	REF02	Predetermination/Preauthorization Number	Enter if applicable.
Insurance Company/Dental Benefit Plan Information				
3	2010BB	NM103	Company/Plan Name, Address, City, State, ZIP Code	Required. If the patient is covered by more than one plan, enter primary insurance company information here. Submit a separate claim with secondary carrier's company/plan name here.
Other Coverage (Mark applicable box and complete items 5-11. If none, leave blank.)				
4	2000B	SBR01	Other dental or medical coverage? Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)	Leave blank if the patient has no other coverage under any other dental or medical plan. If either box is marked, complete items 5-11. If blank, skip to #12.
5	2330A	NM103-104 NM107	Name of Policyholder/Subscriber with Other Coverage (indicated in #4 above)	Enter only if #4 is checked.
6	2320	DMG02	Date of Birth (MM/DD/CCYY)	Enter only if #4 is checked.
7	2320	DMG03	Gender ☐ M ☐ F	Enter only if #4 is checked.
8	2330A	NM109	Subscriber ID (SSN or BCBS Member ID#)	Enter only if #4 is checked.
9	2320	SBR03	Plan/Group Number	Enter only if #4 is checked.
10	2320	SBR02	Patient's relationship to person named in #5 ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	Enter only if #4 is checked.
11	2330B	NM103	Other Insurance Company/Dental Benefit Plan Name, Address, City State, ZIP Code	Enter only if #4 is checked.
Policyholder/Subscriber Information (For insurance company named in #3)				
12	2010BA	NM103-107 N301-403	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix,) Address, City, State, ZIP Code	Required. When the policyholder/subscriber is the patient, the policyholder name in this field must match the patient name, written exactly as it appears on the member ID card, including a middle initial if there is one.
13	2010BA	DMG02	Date of Birth (MM/DD/CCYY)	Required. (MM/DD/CCYY format; year must be four digits)
14	2010BA	DMG03	Gender ☐ M ☐ F	Required. Mark the appropriate gender.
15	2010BA	NM109	Policyholder/Subscriber ID (SSN or BCBS Member ID#)	Required. Enter the member's complete ID number, including all letters and numbers as shown on the BCBS ID card.

837D (ADA 2019) Claim Data Overview and Detail

ADA Field	Loop	Element	Description	Special Instructions
16	2000B	SBR03	Plan/Group Number	Required if present on card. Enter the group number, including all letters and numbers as shown on the BCBS ID card. If the group number is not available, leave blank.
17	N/A	N/A	Employer Name	Required, if applicable.
Patient Information				
18	2000B	SBR02	Relationship to Policyholder/ Subscriber in #12 above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	Check applicable box. The policyholder/subscriber is the person shown on the ID card. When the patient's relationship to the policyholder/subscriber is "Self," the patient's name and the policyholder's name must both match the name displayed on the member ID card, including a middle initial if there is one.
19	N/A	N/A	Reserved for Future Use	Not used. Leave blank and skip to #20.
20	2010BA	NM103-107 N301-403	Name of the Patient (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Required. When the patient is the policyholder (not a covered spouse or child of the policyholder), the patient name in this field must match the policyholder name, written exactly as it appears on the member ID card, including a middle initial if there is one.
21	2010BA	DMG02	Date of Birth (MM/DD/CCYY)	Required. Enter in MM/DD/CCYY format.
22	2010BA	DMG03	Gender ☐ M ☐ F	Required. Mark the appropriate gender.
23	2010BA	CLM01	Patient ID/Account # (assigned by dentist)	Enter if the dentist office has assigned a unique number to identify the patient. This is not required to process the claim.
Record of Services Provided REQUIRED: Enter up to 10 lines of coding per claim. Limit each claim to one form.				
24	2400	DTP03	Procedure Date (MM/DD/CCYY)	Required, except for predetermination claims. Enter in MM/DD/CCYY format.
25	2400	SV304-1	Area of Oral Cavity (two-digit code)	Conditional. Use area of oral cavity code set, when applicable.
26	2400	TOO01	Tooth System (JP or JO)	Enter "JP" code when using ADA's Universal/National Tooth Designation System. Enter "JO" code when using ISO System for Tooth Numbering.
27	2400	TOO02	Tooth Number(s) or Letter(s)	Conditional. Designate the tooth number when the procedure code directly involves a tooth. If a range of teeth is being reported, use a hyphen to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported. Do not prefix tooth numbers with a leading zero.
28	2400	TOO03-1 to TOO03-4	Tooth Surface (single-letter code)	Conditional. This item is necessary when the procedure performed on a tooth involves one or more tooth surfaces. A surface code *may not* be listed twice on the same service line.
29	2400	SV301-2	Procedure Code	Required. Use the appropriate dental procedure code from current version of CDT. Use of deleted procedure codes will result in the claim being returned.
29a	2400	SV301-2	Diagnosis Pointer	Enter letter(s) from #34 that identify the applicable diagnosis code(s). List the primary diagnosis pointer first.
29b	2400	SV301-2	Quantity (01-99)	Enter the number of times the procedure in #29 is delivered to the patient on the date of service in #24. The default value is "01."
30	2400	SV301-7	Description	Enter brief description of service provided.

837D (ADA 2019) Claim Data Overview and Detail

ADA Field	Loop	Element	Description	Special Instructions
31	2400	SV302	Fee	Report dentist's full fee for the procedure.
31a	2400	SV302	Other Fee(s)	If applicable. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, when applicable, and other fees imposed by regulatory bodies.
32	2400	CLM01	Total Fee	Required. Total of all fees listed on the claim.
Missing Teeth Information				
33	2300	DN201	Missing Teeth Information (Place an X on each missing tooth.) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	For identifying missing permanent dentition only.
34	2300	DN201	Diagnosis Code List Qualifier □□ (ICD-10 = AB)	Enter the appropriate code to identify the diagnosis code source. AB = ICD-10-CM
34a	2300	DN201	Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____	Enter up to four applicable diagnosis codes after each letter, with the primary diagnosis code in "A." Required when diagnosis may have an impact on the adjudication of the claim in cases where procedures may minimize risks associated with connection between the patient's oral and systemic health conditions.
35	2300	NTE	Remarks	As needed, to convey concise information pertinent to the claim submission. For BlueDental stand-alone plans, insert DentalXchange, Vyne, or Change Healthcare electronic attachment reference numbers.
Authorizations				
36	2300	CLM09 O106	Patient/guardian signature (for agreement that he/she has been informed of treatment plan, costs of treatment, and the release of information necessary to carry out payment activities related to the claim)	Required. Have the patient or authorized person sign or indicate "signature on file," if applicable. For 837D, enter code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.
37	2300	CLM08 O103	Subscriber signature (for authorization of benefit payments directly to provider)	This is an authorization only and does not establish a contractual relationship between the dentist and the insurance company. For 837D, enter code showing whether the provider has a signed form authorizing the third-party payer to pay the provider.
Ancillary Claim/Treatment Information				
38	2300	CLM05-1	Place of Treatment □ (two-digit code; e.g., 11=office; 22=O/P Hospital)	Required. Enter appropriate two-digit code in box.

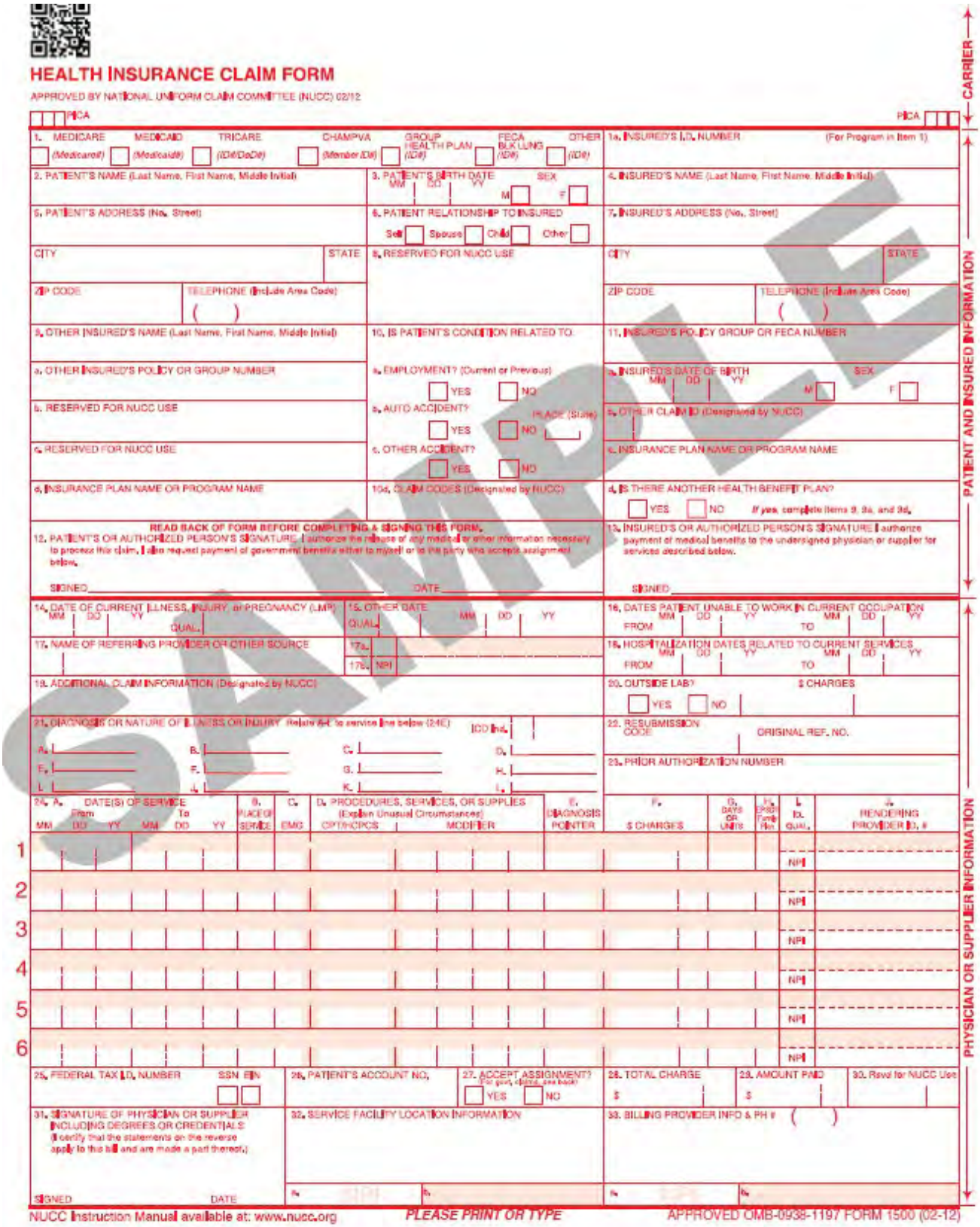
837D (ADA 2019) Claim Data Overview and Detail

ADA Field	Loop	Element	Description	Special Instructions
39	N/A	N/A	Enclosures (Y or N)	For all paper claims, indicate whether enclosures of any type are included with the claim submission. For claims other than BlueDental stand-alone plans, X-rays should *only* be mailed to AZ Blue when specifically requested. For 837D, only claims for BlueDental stand-alone plans may include electronic attachments through DentalXchange, Vyne, or Change Healthcare. All other BlueDental claims with attachments must be submitted via paper to: AZ Blue BlueDental Claims P.O. Box 211424 Eagan, MN 55121
40	2300	DN103	Is Treatment for Orthodontics?	Required. If "no" skip to item 43. A "yes" response requires completion of items 41 and 42. (Refer to the orthodontic claim submission guidelines outlined earlier in this section.)
41	2300	DTP03	Date Appliance Placed (MM/DD/CCYY)	Required, if applicable. (MM/DD/CCYY)
42	2300	DN102	Months of Treatment Remaining	Required, if applicable.
43	2400	SV305	Replacement of Prosthesis?	Required. A "yes" response requires completion of item 44.
44	2400	DTP03	Date of Prior Placement (MM/DD/CCYY)	Required, if applicable. (MM/DD/CCYY)
45	2300	CLM11 CLM11-1 CLM11-2	Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident	Required, if applicable. Check applicable box for occupational illness/injury, auto accident, or other accident.
46	2300	DTP03	Date of Accident (MM/DD/CCYY)	Required, if any box in item 45 was checked. Enter date in MM/DD/CCYY format.
47	2300	CLM11-4	Auto Accident State	Enter the state in which the auto accident noted in #45 occurred. Otherwise, leave blank.
Billing Dentist or Dental Entity (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)				
48	2010AA	NM103 N301-403	Name, Address, City, State, ZIP Code	Required. Enter the name and complete address of the dentist or dental entity that furnished the services to the patient. Use the full nine-digit ZIP code.
49	2010AA	NM109	NPI	Required. Enter the appropriate NPI number for the billing dentist or billing entity. All dental claims must have the billing provider/entity NPI.
50	2010AA	REF02	License number	Enter if the billing dentist is an individual. If a billing entity (e.g., a corporation) is submitting the claim, leave blank.
51	2010AA	REF*EI	SSN or TIN	Required. Enter the federal tax ID number of the provider performing the services.
52	2010AA	PER04	Phone number	Enter the business phone number.
52a	2010AA	REF02	Additional provider ID	We only accept NPI numbers (see line 49). Do not enter other assigned identifiers.
Treating Dentist and Treatment Location Information				
53	2300	CLM06	Treating dentist's signature & date	Required.
54	2310B	NM109	NPI	Required. Enter the NPI number corresponding with the individual treating dentist's name. All dental claims must have the treating dentist NPI.
55	2310B	REF01	License number	Treating dentist license number.

837D (ADA 2019) Claim Data Overview and Detail

ADA Field	Loop	Element	Description	Special Instructions
56	2310C	N301-N403	Address, city, state, ZIP code	Required when different from billing address. Enter the physical location where the treatment was rendered. Must be a street address, not a P.O. Box.
56a	2310B	PRV03	Provider specialty code (taxonomy)	Required. Enter treating professional's taxonomy code (provider specialty code).
57	2010AA	PER04	Phone Number	Enter business phone number of the treating dentist.
58	2310B	REF02	Additional Provider ID	We only accept NPI numbers (see line 54). Do not enter other assigned identifiers.

CMS 1500 – Sample Claim Form (Version 02/12)



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? YES NO PLACE (State)

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)

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										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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

837P (CMS 1500) Claim Data Overview and Detail

The HIPAA Transaction Standard – AZ Blue Companion Guide includes the AZ Blue-specific requirements for submitting 837P (professional) claim transactions. You can obtain the companion guide and testing requirements via our Electronic Business page.

Pages 19-34 to 19-38 list general guidelines and our required data elements for submitting professional claims. **We return claims with missing or invalid data in required fields.** For information and resources related to professional claims, you can visit the CMS website.

Please note:

- We require your billing NPI and tax ID number (TIN) on all professional claims. Claims without this information will be rejected. The NPI and TIN submitted on claims must match those on file for you in our claim system; otherwise, your claims will be returned. To avoid delays, use the Provider Information Change form to notify us of updates to your practice information. You can find the form in the AZ Blue provider portal at "Provider Resources > Forms > Provider Information Change."

  Important: Solo practitioners (sole proprietors) must use the Billing Provider Entity Type Qualifier 1 (= person with name and individual NPI). Professional claims billed under a solo practitioner *should not* include the rendering provider loop 2310B.

  The NPI requirement does not apply to atypical[1] providers.

- *Only* if you are unable to submit professional claims electronically, use the CMS 1500 paper form version (02/12). You must use additional claim forms for more than six lines of codes and charges, with a maximum of three forms per claim.

- We accept ICD-10 codes and follow the CMS claim submission guidelines as outlined in the Medicare Learning Network® (MLN) education articles.

- **ICD-10 coding error messages –** If the ICD-10 code sets are billed incorrectly, we will send you a return notice that includes:
  - Claim error(s) along with the claim ICN (claim number) and description of errors
  - One or more of the code set error messages shown below
  - Instructions for how to correct the error(s) and resubmit (Do not send us the return notice with corrections noted.)

ICD-10 CODE SET ERROR MESSAGES
ICD-10 code set and/or indicator is not valid for date of service.
The discharge and/or through date for the ICD code set combination is invalid.
The ICD diagnosis indicator is missing. Please resubmit with appropriate indicator for the diagnosis code set being used on claim.

[1] Atypical providers, as defined by HIPAA, cannot obtain an NPI; therefore, we will assign a proprietary provider ID. This proprietary ID must be used when submitting CMS 1500 (02/12) claims in field 33b.

837P (CMS 1500) Claim Data Overview and Detail

CMS Field	Loop	Element	Description of Field and Special Instructions
1	2000B	SBR09	Payer type – Optional.
1a	2010BA	NM109	Insured's ID – Required. Enter the complete member ID, including all letters and numbers as shown on the BCBS ID card.
2	2010CA or 2019BA	NM103 NM104 NM105 NM107	Patient's name – Required. Enter the patient's last name, first full name (not nickname) and middle initial. When the patient is the insured (not a covered spouse or child of the insured), the patient name in this field must match the insured name, written exactly as it appears on the member ID card, including a middle initial if there is one.
3	2019CA or 2010BA	DMG02 DMG03	Patient's birth date and sex – Required. Enter the patient's birth date in each sectioned block. The format for the date must be MM/DD/CCYY (year must be four digits). Mark either the M or F block indicating the patient's sex.
4	2010BA	NM103 NM104 NM105 NM107	Insured's name – Required. Enter insured's last name, first full name (not nickname) and middle initial. When the insured is the patient, the insured name in this field must match the patient name, written exactly as it appears on the member ID card, including a middle initial if there is one.
5	2010CA	N302 N401 N402 N403	Patient's address – Optional.
6	2000B	SBR02	Patient's relationship to insured – Required. The insured is the member shown on the ID card (not a covered spouse or child). Indicate the relationship of the patient to the insured by marking the appropriate box. When the patient's relationship to the insured is "Self," the patient's name and the insured's name must both match the name displayed on the member ID card, including a middle initial if there is one.
	2000C	PAT01	
7	2010BA	N301 N302 N401 N402 N403	Insured's address – Required.
8	Reserved for NUCC use		
9	2330A	NM103 NM104 NM105 NM107	Other insured's name
9 (a-d)	2320	SBR03 SBR04	Other insured's policy information – Required, if applicable.
10 (a-c)	2300	CLM11.01 CLM11.02	Patient's condition related to – Required for job-related injury, auto, or other accident. The two-letter state code is required for auto accidents.
10d	2300	HI	Claim codes (designated by NUCC) – Required, if applicable.

837P (CMS 1500) Claim Data Overview and Detail

CMS Field	Loop	Element	Description of Field and Special Instructions
11 (a-d)	2000B 2010BA 2320	SBR03 SBR04 DMG02 DMG03 REF01 REF02	Insured's policy group information – Required if present on card. Enter the group number (including all letters and numbers) as shown on the BCBS ID card. If the group number is not on the ID card, leave blank. For Corporate Health Services (CHS) accounts: • The CHS group number is required in this field (find the number in the AZ Blue provider portal at "Practice Management > Eligibility & Benefits > CHS Group Information.") • Complete remaining fields if information is available.
12	2300	CLM09	Patient's signature – Have the patient or authorized person sign (or indicate "signature on file" in lieu of an actual signature if you have the original signature of the patient or other authorized person on file) authorizing the release of any medical or other information necessary to process the claim.
13	2300	CLM08	Assignment signature – Have the member or authorized person sign (or indicate "signature on file" in lieu of an actual signature if you have the original signature of the member or another authorized person on file) authorizing assignment of payment to you.
14	2300	DTP01 DTP03	Date of illness, injury, or pregnancy – Required for any accident diagnosis. Enter date of onset or last menstrual period and appropriate three-byte qualifier. Required when any box in 10 (a-c) is checked.
15	2300	DTP01 DTP03	Other date – Required if applicable. Enter the date and appropriate three-byte qualifier.
16	2300	DTP03	Dates patient unable to work – Optional.
17	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM101 NM103 NM104 NM105 NM107	Name of referring provider or other source – Required, if applicable. List information and appropriate two-byte qualifier if available. For opioid treatment program, enter prescriber's NPI.
17a	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	REF01 REF02	Other ID number of referring provider (shaded) – Optional. List information if available.
17b	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM109	NPI # of the referring provider –- Required for independent clinical laboratory, DME, radiology, and specialty pharmacy claims. For all other providers, optional. List information if available.
18	2300	DTP03	Hospitalization dates – Required, if applicable.
19	2300 2310A (Referring) 2310B (Rendering)	NTE PWK REF01 REF02	Additional claim information (designated by NUCC) – May be used to report taxonomy code.

837P (CMS 1500) Claim Data Overview and Detail

CMS Field	Loop	Element	Description of Field and Special Instructions
	2310D (Supervising)		
20	2400	PS102	Outside lab and charges – Optional.
21	2300	HI*	Diagnosis – Required. Enter the diagnosis/condition of the patient indicated by the ICD-10-CM code number, including up to seven digits, as appropriate, and the applicable ICD indicator. Enter indicator "0" for Tenth Edition. Enter no more than 12 codes in priority order (primary, secondary condition). • External cause of injury codes are to be used for *secondary* conditions only. • All injury diagnoses require a date of injury in field #14.
22	2300	CLM05-3 REF02	Resubmission code – Required, if applicable. Enter appropriate frequency code (7 or 8).
23	2300	REF02	Prior authorization number and ambulance pick-up ZIP code – Prior authorization number is required, if applicable. If adding a pick-up ZIP code to the prior authorization number, begin at the 15th character position.
24	2310B 2420A	PRV02 REF01 PRV02 REF01	Shaded areas of field 24 – Supplemental information, as appropriate. Following are samples of the types of supplemental information that should be entered in these shaded areas: • Anesthesia duration in hours and/or minutes with start and end time - Use qualifier 7 • Narrative description of unspecified codes - Use qualifier ZZ • National Drug Codes (NDCs) for drugs: include qualifier, NDC code, unit of measure, and quantity. Add narrative description if space allows. - Use qualifier N4 - For unit of measure, use qualifiers as follows ♦ F2 for international unit ♦ GR for gram ♦ ME for milligram ♦ ML for milliliter ♦ UN for unit - For quantity, do not use decimals for whole numbers. For dollar amounts, do not use the dollar sign.
24	Information on services rendered – Required. Enter no more than one unique code and charge on each line. Use additional claim forms for more than six lines of codes and charges, with a maximum of three claim forms per claim. For opioid treatment program, enter codes associated w OTP service.		
24A	2400	DTP03	Date(s) of service – Required. Enter the month, day, and year formatted as MM/DD/YY for each procedure, service, or supply. "From" and "To" dates must be within the same calendar year on the claim or the claim will be returned. If services span multiple years, separate the claim out and bill services within the same calendar year on one claim form.
24B	2300 2400	CLM05-1 SV105	Place of service – Required. Enter the appropriate two-digit place of service (POS) code from the CMS Place of Service Code Set for each item used or service performed.
24C	2400	SV109	EMG (emergency indicator) – Indicate if applicable.
24D	2400	SV101	Procedures, services, or supplies – Required. • CPT/HCPCS – Enter the current CPT-4 procedure code or the appropriate HCPCS code. • Modifiers – Certain services require modifiers. When CPT modifiers are used, they must be placed in the modifier section using an appropriate two-digit modifier. Non-use or inappropriate use of modifiers may result in the claim being returned or inaccurately processed.

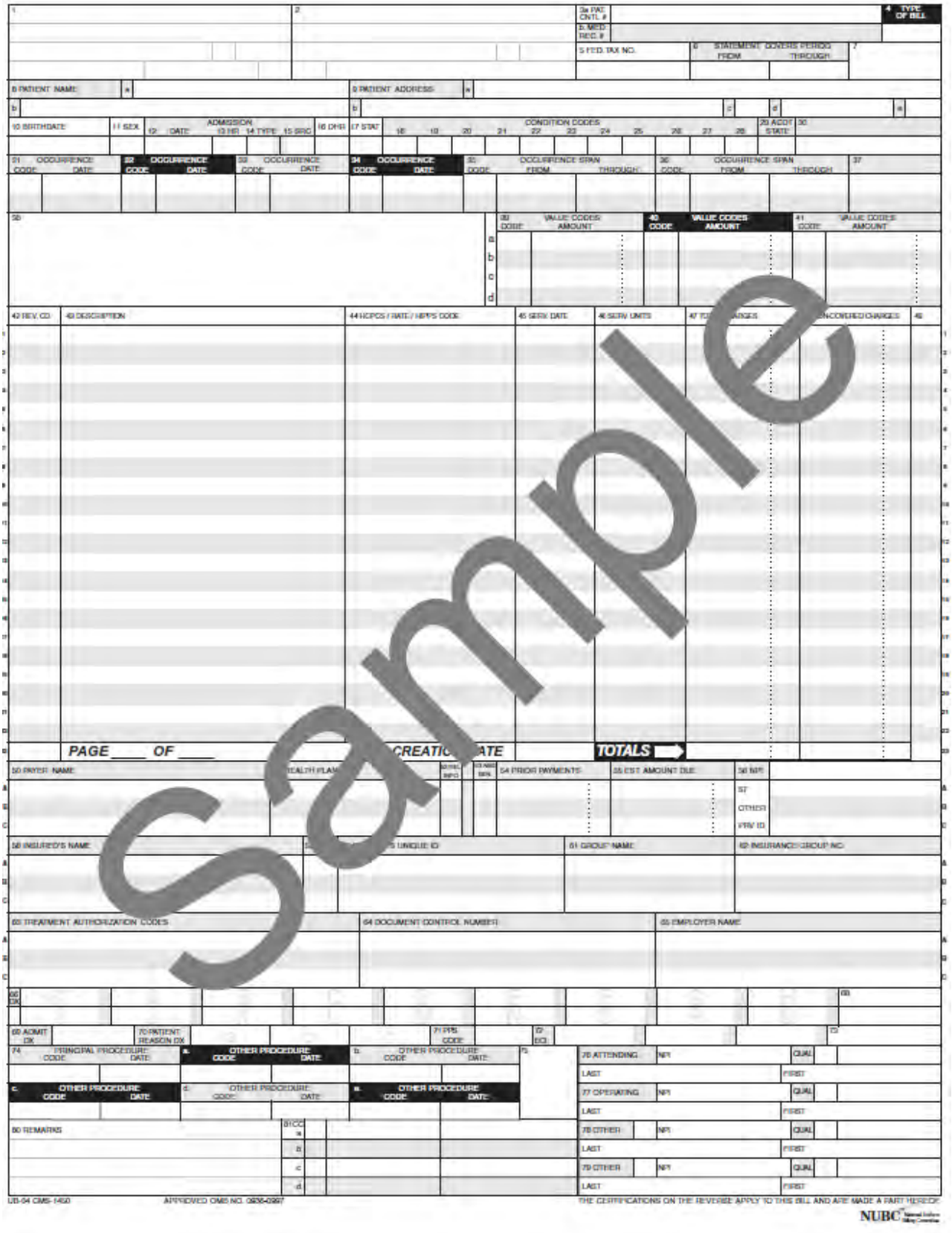
837P (CMS 1500) Claim Data Overview and Detail

CMS Field	Loop	Element	Description of Field and Special Instructions
24E	2400	SV107	Diagnosis pointer – Required. Enter the diagnosis reference letter pointer, as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis. Show at least one diagnosis reference letter but no more than four, in order of priority.
24F	2400	SV102	Charges – Required. Enter the charge for each service in dollars and cents.
24G	2400	SV104	Days or units – Required. Enter the number of days or units (services) when billing for identical/multiple services and anesthesia services, as appropriate. (See "Single units of service" in Section 18.) Providers can find the AZ Blue single units of service tables on the AZ Blue provider portal at "Provider Resources > Guidelines > Claim Pricing." Anesthesia services must be billed using minutes.
24I	2400	SV111 SV112	EPSDT/family plan – Leave blank.
24J	2310B 2420A	PRV02 REF01 PRV02 REF01	ID qualifier Shaded areas – Leave blank.
24J	2310B 2420A	PRV03 REF02 NM109	Rendering provider NPI – Shaded areas: Leave blank. Unshaded areas: Enter the NPI number in field 24j when the billing provider or organization NPI *is not the same* as the rendering provider NPI (i.e., *only* if it is different from data recorded in field 33a). All NPI numbers on lines 1–6 must be identical or the claim will be returned.
25	2010AA	REF01 REF02	Federal tax ID number – Required. Enter the federal tax ID number associated with the provider performing the services. The federal tax ID must be on file with AZ Blue for all providers billing under it. If a provider is not updated in our system with this tax ID, claims may be processed as out-of-network, causing unnecessary delays and adjustments.
26	2300	CLM01	Patient's account number – Required. Letters and numbers. Enter no more than 14 characters.
27	2300	CLM07	Accept assignment – Required.
28	2300	CLM02	Total charges – Required. Enter the sum of charges listed in items 24f, lines 1–6.
29	2300 2320	AMT02	Amount paid – Optional.
30	Reserved for NUCC use		
31	2300	CLM06	Signature of physician or supplier – Required. Physician or supplier must sign and date. (If a locum tenens provider rendered the services, the locum tenens' name and address should be noted in this space.)
32	2310C (Service Facility)	NM103 N301 N401 N402 N403	Service facility location information – Required. Enter the name, address, city, state, and nine-digit ZIP code of the location where the services were rendered. Do not use commas, periods, or other punctuation in the address. Enter a space between town name and state code; do not include a comma.
32a	2310C	NM109	NPI # (service facility) – Optional. Enter the organization NPI number of the service facility location.
32b	2310	REF01 REF02	Other ID # (shaded area) – Leave blank.
33	2010AA	NM103 NM104 NM105 NM107 N301	Billing provider info and phone # – Required. If the tax ID is for a group practice, rather than an individual provider, you must include the group practice name here. Enter the provider's or supplier's billing name, address, nine-digit ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st line: name; 2nd line: address; 3rd line: city, state, and nine-digit ZIP code.

837P (CMS 1500) Claim Data Overview and Detail

CMS Field	Loop	Element	Description of Field and Special Instructions
		N401 N402 N403 PER04	Note: The billing provider address must be a street address or physical location, not a PO Box.
33a	2010AA	NM109	NPI # – Required on all professional claims, with the exception of atypical providers. Enter the NPI of the billing provider. If the rendering provider is affiliated with a group, you must enter the organization NPI of the group practice. For opioid treatment program, enter the organization NPI. Except in limited, temporary locum tenens situations, no physician level provider (which includes, but is not limited to, medical doctors, doctors of osteopathy, podiatrists, dentists, and chiropractors) may bill for services provided by another physician-level provider, or use another physician-level provider's NPI number. No mid-level provider (which includes, but is not limited to, nurse practitioners, certified registered nurse anesthetists, physician assistants, and certified nurse midwives) may bill for services rendered by a physician-level provider.
33b	2000A 2010AA 2010BB	PRV03 REF01 REF02	Required. (shaded area) –Enter taxonomy code. Special note for atypical providers only: This field is required. Enter the assigned AZ Blue proprietary provider number. Use the qualifier 1B followed by the assigned AZ Blue proprietary provider ID # for the billing provider. (No spaces between the 1B qualifier and the assigned AZ Blue proprietary number. The letter "B" can be upper- or lowercase.)

UB-04 – Sample Claim Form (CMS 1450)



837I (UB-04) Claim Data Overview and Detail

The HIPAA Transaction Standard – AZ Blue Companion Guide includes the AZ Blue-specific requirements for submitting 837I (institutional) claim transactions. You can obtain the companion guide and testing requirements via our Electronic Business page.

Pages 19-41 through 19-44 list general guidelines and our required data elements for submitting institutional claims. **We return claims with missing or invalid data in required fields.** For billing information related to institutional claims, you can use the NUBC Official UB-04 Data Specifications Manual. You may find AZ Blue-specific information in our AZ Blue Outpatient Coding Guide, available via our Claims and Remit page under Claim Coding.

Please note:

- We require your billing NPI and tax ID number (TIN) on all institutional claims. Claims without this information will be rejected. The NPI and TIN submitted on the claim must match those on file for you in our claim system; otherwise, your claims will be returned. To avoid delays, use the Provider Information Change form to notify us of updates to your provider information. Find the form in the AZ Blue provider portal at "Provider Resources > Forms > Provider Information Change."
- Taxonomy codes are required for all Medicare Advantage claims and we encourage you to use them on all claims. Refer to form locator 81CC (a-d) for more details.
- We accept ICD-10 codes and follow the CMS claim submission guidelines as outlined in the Medicare Learning Network® (MLN) education articles.
- **ICD-10 code set error messages –** If the ICD-10 code sets are billed incorrectly, we will send you a return notice that includes:
    - Claim error(s) along with the claim ICN (claim number) and description of errors
    - One or more of the code set error messages shown below
    - Instructions for how to correct the error(s) and resubmit (Do not send us the return notice with corrections noted.)

ICD-10 CODE SET ERROR MESSAGES
ICD-10 code set and/or indicator is not valid for date of service.
The discharge and/or through date for the ICD code set combination is invalid.
The ICD diagnosis indicator is missing. Please resubmit with appropriate indicator for the diagnosis code set being used on claim.

837I (UB-04) Claim Data Overview and Detail

Form Locator	Loop	Element	Description of Contents
1	2010AA	NM103 N3, N4	Untitled – Required. Provider name, address, and telephone number. The physical address is required; P.O. boxes are not permitted. The ZIP code must be nine digits.
2	2010AB	NM103 N3, N4	Unlabeled field – Optional. If different from field 1, enter "pay to" name, address, and telephone number. A post office box is acceptable in this field.
3a	2300	CLM01	Patient control number – Required. Enter the patient control number. The number will appear on the remittance advice (RA).
3b	2300	REF02	Medical record number – Optional.
4	2300	CLM05	Type of bill – Required. This four-character code gives three specific pieces of information after a leading zero. The second digit identifies the type of facility, the third classifies the type of care, and the fourth indicates the sequence of this bill in this particular episode of care. Please note the following regarding interim bills: • Acute care hospitals that are reimbursed a MS-DRG payment for an inpatient stay may not submit interim bills. These claims will be returned to the provider. The DRG will be assigned based on the diagnosis code(s) at the time of discharge. • Skilled nursing facilities that are reimbursed a per diem payment for an inpatient stay may submit interim bills. Interim bills must be submitted electronically. • Outpatient interim bills cannot be submitted. Outpatient services, even for the same "course of treatment," should be submitted as recurring and not an interim bill (e.g., therapy services, home health).
5	2010AA	REF02	Federal tax number – Required. Enter the tax ID number for the provider. (TIN/NPI validation edits are in place.)
6	2300	DTP03	Statement covers period – Required. Enter inpatient dates from the earliest date of service through date of discharge or outpatient date(s) of service in MMDDYY format. Outpatient surgery and ASC claims provided on a single day should be entered with the date (MMDDYY) in both the "FROM" and "THROUGH" fields. *Do not bill multiple surgical dates on a single claim.* Outpatient services "statement covers period" need to be within the same calendar year or the claim will be returned. If services span multiple years, separate the claim out and bill services within the same calendar year on one claim.
7			Unlabeled field – Leave blank.
8a	2010BA	NM106	Patient ID number – Required. Enter the patient's ID number, including all letters and numbers.
8b	2010BA	NM103 NM104 NM105	Patient name – Required. Enter the patient's last name, first name, and middle initial. When the patient is the insured (not a covered spouse or child of the insured), the patient name in this field must match the insured name, written exactly as it appears on the member ID card, including a middle initial if there is one.
9a	2010BA	N3	Patient address street – Required. Enter patient's street address.
9b	2010BA	N4	Patient address city – Required. Enter patient's city.
9c	2010BA	N4	Patient address state – Required. Enter patient's state code.
9d	2010BA	N4	Patient address ZIP – Required. Enter five- or nine-digit ZIP code.
9e	2010BA	N4	Patient address country code – Optional.
10	2010BA	DMG02	Birth date – Required. Enter the patient's birth date in MMDDCCYY format.
11	2010BA	DMG03	Sex – Required. Enter the patient's gender as "M" or "F" or "U" (for unknown).
12	2300	DTP03	Admission date – Required on inpatient, home health, and hospice claims. Enter the date in MMDDYY format. On inpatient claims, enter the date of admission. On home health and hospice claims, enter the start of care date. (Admission date is not allowed on OP claims.)
13	2300	DTP03	Admission hour – Required for inpatient claims except for type of bill 021X, for the billing period on the claim. Enter the hour of admission (00-23). When not applicable, this field should be left blank.
14	2300	CL101	Priority (type) of admission or visit – Required. Enter the type of admission code.
15	2300	CL102	Point of origin (SRC) – Required on all bill types. Enter the point of origin for admission code.
16	2300	DTP03	Discharge hour (DHR) – We require this field for final inpatient claims, with the exception of type of bill 021X. Enter discharge hour (00-23). If not applicable, leave blank.

837I (UB-04) Claim Data Overview and Detail

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17	2300	CL103	Patient discharge status (STAT) – Required. Enter the patient status code.
18-28	2300	HI*	Condition codes – Enter the condition code(s), if applicable.
29	2300	CLM11-4	Accident state – Required when services on this claim are related to an auto accident.
30			Unlabeled – Leave blank.
31-34, a-b	2300	HI*	Occurrence codes and dates – Enter the occurrence code(s) and date(s) in MMDDYY format. (Use Occur Code 10 when billing services related to pregnancy/maternity.)
35-36, a-b	2300	HI*	Occurrence span codes and dates – Enter the occurrence code(s) and date/span(s) in MMDDYY format.
37	N/A	N/A	Untitled – Leave blank.
38	N/A	N/A	Responsible party name and address – Optional.
39-41, a-d	2300	HI*	Value codes and amounts – Enter the value code(s) and related amount(s) in ascending letter-number order, if applicable. Fields 39a-41a are to be filled before the "b" fields.
42	2400	SV201	Revenue code(s) – Required. Enter appropriate revenue codes for services provided to explain each charge in field 47. List all revenue codes in ascending numerical order. Additionally, there is no fixed "Total" line in the charge area. Enter revenue code 0001 and the total charges in field 47 "Totals" at the bottom of the column. • Also see "Miscellaneous Revenue Code Information" in Section 18. • Enter no more than one unique code and charge on each line.
43	N/A	N/A	Revenue code description/Medicaid drug rebate reporting (NDC) – Optional. • Enter the revenue code description • National Drug Codes (NDCs) for drugs: include qualifier, NDC code, unit of measure, quantity - Use qualifier N4 – first two positions, left justified - NDC – 11 digits, no hyphens - For unit of measure, use qualifiers as follows: ♦ F2 for international unit ♦ GR for gram ♦ ME for milligram ♦ ML for milliliter ♦ UN for unit - For unit quantity, do not use decimals for whole numbers
44	2400	SV202-2	HCPCS/rate/HIPPS codes/modifiers – Required on all outpatient services, including home health. • Inpatient – Enter accommodation rate for room and board; otherwise, leave blank. • Outpatient, ASC, and rehab – Enter the CPT/HCPCS code and any modifiers that apply (up to four). • Renal dialysis – Leave blank. If charges are not part of the composite rate, enter the CPT/HCPCS code and any modifiers that apply (up to four). All others – Enter the HIPPS code here, when applicable (HH, SNF, IRF).
45	2400	DTP03	Service dates – Required on each service line billed on all outpatient claims. Enter service date in MMDDYY format. Do not bill multiple surgical dates on a single outpatient facility claim.
46	2400	SV205	Units of service/service units – Enter the number of days/units. Enter a quantitative measure of service rendered by revenue category to or for the patient, to include items such as number of days, miles, pints of blood, or renal dialysis treatments. (For more information about single units of service, see Section 18. The AZ Blue Single Units of Service Table is accessible via the AZ Blue provider portal at "Provider Resources > Guidelines > Claim Pricing.")
47	2400	SV203	Total charges – Enter the total charges. Total the column at the bottom.
48	2400	SV207	Non-covered charges – Enter non-covered charges, if applicable.
49			Unlabeled charge columns – Not required.
50, a-c	2330B	NM103	Payer name – All payers need to be listed in the A-C order.
51, a-c	2330B	NM109	Health plan ID – Report the national health plan identifier when one is established; otherwise, report the number Medicare has assigned.

837I (UB-04) Claim Data Overview and Detail

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52, a-c	2300	CLM07	Release of information certification indicator (Rel. Info) – Required.	
53, a-c	2300	CLM08	Assignments of benefits certification indicator (Asg. Ben.) – Required.	
54, a-c	2320	AMT02	Prior payments – Required, if applicable.	
55, a-c	2300	AMT02	Estimated amount due – Leave blank.	
56	2010AA	NM109	National provider ID (NPI) – Required. (TIN/NPI validation edits are in place.)	
57, a-c	2010AA 2010BB	REF01 REF02	Other provider ID – Optional. Special note for atypical providers only: This field is required. Enter the assigned AZ Blue proprietary provider number. Use the qualifier 1B followed by the assigned AZ Blue proprietary provider ID # for the billing provider. (No spaces between the 1B qualifier and the assigned AZ Blue proprietary number. The letter "B" can be upper- or lowercase.)	
58, a-c	2010BA	NM103 NM104 NM105	Insured's name – Enter the last name, first name, and middle initial of the insured, corresponding to the payers listed in FL50 A, B, C. When the insured is the patient, the insured name in this field must match the patient name, written exactly as it appears on the member ID card, including a middle initial if there is one.	
59, a-c	2000B	SBR02	Patient's relationship to insured (P. Rel.) – Required. Must be a valid value. Enter the patient's relationship to the insured, corresponding to the name of the insured in FL58 A, B, C. When the patient's relationship to the insured is "Self," the patient's name and the insured's name must both match the name displayed on the member ID card, including a middle initial if there is one.	
60, a-c	2010BA	NM109 REF02	Cert.-SSN-HIC-ID number – Enter the insured's ID number assigned by the payer to identify the patient corresponding to the name of the insured in FL58 A, B, C. For the BCBS payer line, all letters and numbers of the member ID are required. List any other payer's policyholder ID number (when applicable to that payer).	
61, a-c	2000B	SBR04	Insured's group name – Required only if FL62 is not entered and group name is available.	
62, a-c	2000B	SBR03	Insurance group number – Enter the insurance group number corresponding to the name of the insured in FL58 A, B, C. For Corporate Health Services (CHS) accounts, the CHS group number is required in this field. (Find the group number in the AZ Blue provider portal in "Practice Management > Eligibility & Benefits > CHS Group Information.")	
63, a-c	2300	REF02	Treatment authorization codes – Enter the precertification/authorization number, if applicable. (For Medicare Advantage claims, home health providers should enter the OASIS code.)	
64, a-c	2300	REF02	Document control number – Leave blank.	
65, a-c	2320	SBR	Employer name – Optional.	
66	N/A	N/A	Diagnosis and procedure code qualifier (ICD version indicator) – Enter indicator "0" for Tenth Edition (not required by Medicare).	
67	2300	HI01	Principal diagnosis code – Required. Enter the principal diagnosis code from the ICD-10-CM, as appropriate. (Omit the decimal point.) For inpatient services at acute care hospitals, include the POA indicator in the eighth digit of the principal diagnosis code.	Valid POA values include: • Y – the diagnosis was present on admission • N – the diagnosis was not present on admission • U – it is unknown if the diagnosis was present on admission • W – it is clinically undetermined if the diagnosis was present on admission • Blank – the diagnosis is exempt from reporting the POA * Claims for inpatient services at acute care hospitals failing the above-referenced criteria will be returned, indicating that the POA was billed incorrectly.
67a-q	2300	HI01-2	Other diagnosis codes – Enter additional diagnosis codes from the ICD-10-CM, as appropriate. (Omit the decimal point.) For inpatient services at acute care hospitals, include the POA indicator in the eighth digit of each of the secondary diagnosis codes.	
68	N/A	N/A	Blank field – Not used.	

837I (UB-04) Claim Data Overview and Detail

Form Locator	Loop	Element	Description of Contents
69	2300	HI02-2	Admitting diagnosis code – We require completion of the "Admitting Diagnosis" field in form locator 69 when the claim involves an inpatient admission. Required on type of bill 012X, 022X, and inpatient TOBs, with the exception of 028X, 065X, 066X, 084X, and 086X. Enter the ICD-10-CM code, as appropriate, without the decimal point. If the data is missing or invalid, the claim will be returned.
70 a-c	2300	HI02-2	Patient reason for visit code – We require the patient reason for visit code for all unscheduled outpatient visits, which are defined as type of bill 013X, 085X, or 078X, together with type of admission code 1, 2, or 5, *and* containing an emergency department, observation room, or urgent care revenue code 045X, 0516, 0526, or 0762. For outpatient claims, report the ICD-10 diagnosis code, as appropriate, which best describes the reason for the patient's visit. If the data is missing or invalid, the claim will be returned.
71	2300	HI01-2	Prospective Payment System code (PPS) – Not used.
72, a-c	2300	HI03-2	ECI-code (external cause code) – Required, if applicable.
73			Unlabeled field – Leave blank.
74	2300	HI01-2	Principal procedure code and date – Required, if applicable, on inpatient claims when a procedure was performed. It is not allowed on outpatient claims. Enter the full ICD-10-PCS principal procedure code, as appropriate, for the primary procedure followed by the date of service (MMDDYY).
74 a-e	2300	HI*	Other procedure codes and dates – Required, if applicable, on inpatient claims when a procedure was performed. It is not allowed on outpatient claims. Enter the full ICD-10-PCS CM codes, as appropriate, identifying the procedures, other than the principal procedure, followed by the dates of service (MMDDYY).
75			Unlabeled field – Leave blank.
76	2310A	NM109 REF02 NM103 NM104	Attending provider name and identifiers (NPI) – Required, except for non-scheduled transportation claims. • NPI: Enter the attending physician's NPI #. • Qualifier: Optional. Enter the qualifier corresponding to the provider ID number listed in the subsequent field. • Last Name/First Name: Enter the last name/first name of the attending physician.
77	2310B	NM109 REF02 NM103 NM104	Operating provider name and identifiers (NPI) – Required, if available, when a surgical procedure is listed on this claim. • NPI: Enter NPI # of the individual with the primary responsibility for performing the surgical procedure(s). • Qualifier: Optional. Enter the qualifier corresponding to the provider ID number listed in the subsequent field. • Last Name/First Name: Enter the last name/first name of the physician with the primary responsibility for performing the surgical procedure(s).
78 and 79	2310B	NM109 REF02 NM103 NM104	Other provider name and identifiers (NPI) – Required, if available. Enter the NPI number, applicable provider type qualifier codes/secondary identifier qualifiers, and name of the individual, when applicable.
80	2300	NTE01	Remarks – Enter any remarks needed to provide information not shown elsewhere on the bill.
81CC a-d	2300	HI*	Code-Code field – Entry of a taxonomy code is required. Enter the appropriate taxonomy code for the billing provider in field 81CC a-d, when applicable. The healthcare provider taxonomy code is a unique, 10-character code that allows a provider to identify a specialty category. Providers may have one or more taxonomy codes associated with their NPI#; however, enter only one taxonomy code that is applicable to the claim. Use the qualifier B3 (Health Care Provider Taxonomy Code) in the first smaller box in this field, followed by the 10-digit taxonomy code. Reporting any other codes as approved by the NUBC is optional.