Billing Requirements

Professional Claim Data Fields

WellSense HEALTH PLAN

Effective March 1, 2016**,** WellSense Health Plan requires all providers to report specific data fields on all Non Institutional Claims Submissions. The following chart identifies the data field elements and requirements a provider must report for non-institutional claims. Failure to submit "Required" fields may result in the claim being returned to the provider or claim denial. The value to the left of the chart represents the form locator field on the CMS-1500 paper claim form. For the corresponding electronic claim submission format, claims must be submitted in accordance with HIPAA compliant 837P standard format.

Box	Field Name	Submission Requirements	
		Paper CMS-1500	Electronic 837P
1	Type of Coverage	Optional	Optional
1a	Insured's ID Number	Required	Required
2	Patient's Name	Required	Required
3	Patient's Date of Birth	Required	Required
4	Insured's Name	Required	Required
5	Patient's Address	Required	Required
6	Patient Relationship to Insured	Required	Required
7	Insured's Address	Required	Required
8	Reserved for NUCC use	NA	NA
9	Other Insurance Information	Required, if applicable	Required, if applicable
9a	Other Insured's Policy or Group Number	Required, if applicable	Required, if applicable
9b	Reserved for NUCC use	NA	NA
9c	Reserved for NUCC use	NA	NA
9d	Insurance Plan	Required	Required
10 a-c	Is Patient's Condition Related To	Situational	Situational
10 d	Reserved for NUCC use	NA	NA
11	Insured's Policy Group or FECA Number	Situational	Situational
11a	Insured's Date of Birth and Sex	Situational	Situational
11b	Other Claim ID	Situational	Situational
11c	Insurance Plan Name or Program Name	Situational	Situational
11d	Another Health Benefit Plan	Required, if applicable	Required, if applicable
12	Patient's or Authorized Person's Signature	Situational	Situational
13	Insured's or Authorized Person's Signature	Situational	Situational
14	Date of Current Illness/Injury/Pregnancy	Required	Required
15	Other Date	Situational	Situational
16	Dates Patient unable to Work In Current Occupation	Situational	Situational
17	Name of Referring Provider or Other Source	Required	Required
17B	ID Number of Rendering Provider	Required	Required
18	Hospitalization Dates Related to Current Services	Situational	Situational
19	Additional Claim Information	Situational	Situational
20	Outside Lab	Required, if applicable	Required, if applicable
21	Diagnosis or Nature of Illness/Injury	Required	Required
22	Resubmission Code	NA	NA
23	Prior Authorization Number	Required, if applicable	Required, if applicable
24A	Date of Service From/To	Required	Required
24B	Place of Service	Required	Required
24C	EMG	Situational	Situational
24D	Procedure Codes/Modifiers	Required, if applicable	Required, if applicable
24F	Total Charge	Required	Required
24G	Days or Units	Required	Required
24H	EPSDT Family Plan	Required, if applicable	Required, if applicable

Billing Requirements

Professional Claim Data Fields

WellSense HEALTH PLAN

Box	Field Name	Submission Requirements	
		Paper CMS-1500	Electronic 837P
24I	ID Qual	NA	NA
24J	Rendering Provider ID	Required	Required
25	Federal Tax ID Number	Required	Required
26	Patient's Account No.	Required	Required
27	Accept Assignment	Required	Required
28	Total Charges	Required	Required
31	Signature of Provider	Required	Required
32 a-b	Name and Address of Facility	Required, if applicable	Required, if applicable
33	Provider/Supplier's Billing Number and Address	Required	Required
33a	Billing Provider/Group NPI	Required	Required

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) 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. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID 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. BALANCE DUE $

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org