Univera Healthcare Dental Guidebook

A Resource guide for dental providers

March 2024

univera HEALTHCARE

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Overview of Univera Healthcare

Univera Healthcare, headquartered in Buffalo, NY, is part of a $6 billion family of companies that finances and delivers health care services across upstate New York and long-term care insurance nationwide. Collectively, the enterprise provides health insurance to about 1.5 million members and employs about 3,500 New Yorkers.

Our corporate mission is to provide access to affordable and effective health care services, be responsible stewards of our communities' health care resources and work to continually improve the health of our members and those in the communities that we serve.

Your participating provider agreement for dental services includes the following subsidiaries and affiliates (the several different entities within the holding company structure, including, without limitation. Lifetime Benefit Solutions, Inc., Univera Healthcare, and any others that we subsequently inform you have become a part of the holding company structure).

Univera Healthcare Regions and Counties (In Area)

Western New York Region:

- Allegany County
- Cattaraugus County
- Chautauqua county
- Erie County
- Genesee County
- Niagara County
- Orleans County
- Wyoming County

In addition, Univera Healthcare members can access in-network dental providers in the following 31- county area:

Cayuga	Broome	Livingston	Clinton
Cortland	Chemung	Monroe	Delaware
Onondaga	Chenango	Ontario	Essex
Jefferson	Schuyler	Seneca	Franklin
Lewis	Steuben	Wayne	Fulton
Oswego	Tioga	Yates	Hamilton
St. Lawrence			Herkimer
Tompkins			Madison
			Montgomery
			Oneida
			Otsego

Contiguous Counties

Many of our participating providers are located in, or provide services in, counties that border Univera Healthcare's servicing area. These are referred to as contiguous counties, and are located in New York, Pennsylvania, and Vermont.

Out-of-Area Providers

Out-of-area providers are unable to participate with the Health Plan directly, outside of our selling area. Out-of-area providers can send a copy of their W-9 with the first claim for a file to be created for claims processing purposes.

The Dental Portal

Our website, UniveraHealthcare.com, includes a secure area where dentists and office staff can log in to view member's eligibility, benefits, and claims. To gain access to this secure area, dentists must first register, create an account, validate the email address provided, and set up any staff requiring access to the dental portal.

For more information on registering and creating an account, go to Provider.UniverHealthcare.com and click on the Frequently Asked Questions or the Provider Portal Registration and Maintenance Guide for Dentists.

For detailed information on navigating and interpreting the dental portal, tips, trends, and items under construction, go to Resources, Practice Management, and the Presentations & Guidebooks tab and click on the Dental Portal Training Manual or Dental Portal Latest Information.

To receive our dental newsletter electronically, click Sign Up in the "Opt in to stay informed!" text box, complete the free form areas, select a role, select General Dentistry in the Practice Specialty, select the county, and click Submit.

Contact Us

Need Help? We are here for you!

When an inquiry is not answered using the dental portal, keep the following contact list on hand for a quick, easy reference.

<table>
<tr><th colspan="2">Who Do I Contact?</th></tr>
<tr><th>Participating Providers</th><th>Non-Participating Providers</th></tr>
<tr><td>Call Web Security Help Desk at 1-800-278-1247 for assistance with the web.

Call Dental Customer Care at 1-800-724-1675 for:

▪ Eligibility
▪ Benefits
▪ Pretreatment estimates
▪ Claims
▪ Remittances
▪ Checks

Contact Provider Relations at 1-716-857-4647 or by email at UniveraPR@univerahealthcare.com for:

▪ Provider contracting questions
▪ Staff education
▪ Recurring issues
▪ Enrollment and demographic updates</td><td>Call Web Security Help Desk at 1-800-278-1247 for assistance with the web.

Call Dental Customer Care at 1-800-724-1675 for:

▪ Eligibility
▪ Benefits
▪ Pretreatment estimates
▪ Claims
▪ Remittances
▪ Checks</td></tr>
</table>

Contact List & Quick Reference Guide	
Claims Submission Address	Univera Healthcare PO Box 211256 Eagan, MN 55121
Enrollment	Email for questions regarding enrollment and demographic updates: UniveraPR@Univerahealthcare.com
HealthPlex – handles members with Medicaid Managed Care (MMC), Child Health Plus (CHP), Essential Plan (EP), and Dual Special Needs Plan (DSNP).	Members: 1-866-795-6493 Providers: 1-877-282-7012
Instamed	1-866-InstaMed or 1-866-467-8263
National Plan & Provider Enumeration System (NPPES)	1-800-465-3203 or https://npiregistry.cms.hhs.gov/
Smart Data Solutions (SDS) Provider Submission Portal (Virtual Mailbox)	SDS Provider Portal for Claims | Providers | Univera Healthcare
Tesia/Renaissance/RemoteLite	1-800-724-7240 or info@tesia.com
Univera Healthcare website	Navigate to the resources section at https://provider.univerahealthcare.com/resources/dental for: ▪ Forms and documents ▪ News and updates ▪ Staff training information ▪ Update practice information ▪ Attestations & Certifications
Zelis	Provider Enrollment 1-855-496-1571 Provider Services 1-877-828-8770

Join Us!

Enrollment in Univera Healthcare Network

Joining our network requires the following documents:

- Application for dental enrollment
- Signed dental agreement
- W9
- Copy of New York License
- Copy of malpractice certificate
- Copy of DEA license if applicable

Once your enrollment documents and contract have been submitted for processing, please allow up to 30 days for enrollment to be completed. To follow up on enrollment status, email Univera Provider Relations, at: UniveraPR@UniveraHealthcare.com.

Participating Provider Practice Changes

Demographic Changes

We recommend all participating dentists to review the practice information that we have on file to ensure that it is up to date. This information is displayed in our Provider Directory and serves as a reference guide for members seeking your services.

You can check this information by:

- Visiting our website, UniveraHealthcare.com
- Select the Find A Doctor tab to get started
- Choose the provider network in which you participate
- Select the Health Plan product(s) in which your office participates
- Enter the provider's first and last name and click Search

Participating providers can update practice information (practice name, provider name, phone number, fax number, address, office hours, or any other data changes that have occurred within the practice) by completing our Demographic Changes form and submitting it one of the following ways:

- Electronically to Provider.UniveraHealthcare.com
- Printing and faxing it to 1-800-676-6285
- Printing and mailing it to Univera Healthcare Attn: Provider Relations 205 Park Club Lane Buffalo, NY 14221.

*When submitting address or service location updates: Service locations must be a street level address. PO boxes are not acceptable.

Types of Dental Insurance Products

Univera Healthcare offers its members several dental care coverage options:

- Univera Healthcare Access Dental
- Univera Healthcare Dental Select
- Univera Healthcare Dental Traditional
- Medicare
- Medicare Advantage

Member Card Tips

Member cards contain vital information to assist you in submitting clean claims and receiving prompt claim reimbursement when applicable.

At every visit, be sure to make a copy of your patient's card (front and back) and verify the card information against the member's eligibility and benefit information by calling our Dental Customer Care line, 1-800-724-1675.

Keep the following in mind when reviewing a patient's member card:

- Logo: Univera Healthcare logo is located on all plan member cards
- Subscriber Name: Name of the person holding the policy
- Subscriber ID Number: This number is vital for correct claim processing
- Copay Amount: Collect copays from the patient at the time of service
- Dependent Information: Dependents will not be listed on the card
- Telephone Numbers/Instructions: The telephone numbers for Dental Customer Care are located on the back of the card. If you have questions regarding a member's benefits, please do not hesitate to call for assistance

Claim Submission

Participating providers with Univera Healthcare need to submit all claims, including those for local subscribers, out-of-area subscribers, and primary and secondary claims, to us. Most participating provider agreements contain a time limit within which claims will be accepted, so you should submit all claims as soon as possible after rendering service. Claims submitted after that time may deny for late filing.

American Dental Association(ADA) Claim Form and Instructions

Visit the ADA Dental Claim Form website for the most recent ADA Dental Claim Form and completion instructions. Here are a few reminders for completing a standard claim form:

- Dental claims do not require a prefix
- Dental claims do not require a group number
- Dental payor ID is 00802
- Please allow 30 days for claim processing
- Commas are needed in the name field to ensure that the first and last names are correctly identified in our system: Doe, Jane, C

Requirements for Electronic and Paper Claims

National Provider Identifier (NPI)

Univera Healthcare requires an NPI for all participating providers regardless of whether they submit electronic or paper claims. NPI is an identification number assigned by the Federal government to all providers considered to be HIPAA covered entities.

An NPI is unique to an individual dentist (Type 1 NPI) or dental practice organization (Type 2 NPI) and has no intrinsic meaning. Type 1 includes health care providers who are individuals, including dentists and all sole proprietors, as an individual is eligible for only one NPI. Type 2 includes health care provider organizations, including physicians' groups (multiple providers), hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

If you are an incorporated practice that gets paid under a business or corporate name, you need to have a group NPI, or Type 2 NPI. However, each practitioner also needs an individual, or Type 1, NPI. To obtain a group NPI visit the NPPES website at https://nppes.cms.hhs.gov/#.

Additional information on NPI and enumeration can be obtained from the American Dental Association's website at http://www.ADA.org and the National Plan & Provider Enumeration System (NPPES) website at https://nppes.cms.gov/#.

Taxonomy Code

Taxonomy codes are used to indicate the specialty associated with the assigned NPI. Providers may have one NPI with multiple taxonomy codes indicating each specialty for that practitioner. Visit the National Plan & Provider Enumeration System website to find taxonomy codes https://nppes.cms.hhs.gov/#.

Tips for A Successful Paper Claim Submission

To help ensure that claims are processed quickly and correctly, please check the following before submitting the claim:

A. Avoid handwritten claims
B. All information must be submitted as clearly as possible, such as using uppercase characters
C. Validate the address, city, state, and ZIP code against the United States Postal Service (USPS) database.
D.
   - Both primary and secondary/alternative city names will be accepted
   - Never use city names that are listed on the CITY NAMES TO AVOID list
   - If a city name has spaces, the claim submission needs to match the USPS format exactly
   - Abbreviations are only accepted if listed as a valid city name and must match USPS exactly

If a rejection is received, please make the needed corrections, and print a new claim.

- Do not cross out or correct data on the original copy of the claim submitted for processing
- Do not resubmit the correction with the return letter or the original claim as this will make it appear as if two claims are being submitted.
- The field causing the rejection will have parentheses (xxx) around the incorrect data.

Dental Portal Claim Submission

Registered Dentists can submit dental claims directly through the Dental Portal. Refer to the “Submit Dental Claims” section of the Dental Portal Training Manual for step by step instructions.

Register with Tesia for Electronic Billing

If you do not currently have an account with Tesia, please consider registering. Tesia offers:

- Access to real-time explanation of benefit information 24 hours a day, seven days a week, which may reduce the need to contact the Univera Healthcare Dental Customer Care Unit
- Remote Lite e-claims processing, an electronic transaction management system that interfaces with your existing practice management software to submit dental claims to insurance companies.

For additional information about the services that Tesia can provide your practice, visit tesia.com.

Sign Up to Use Our Virtual Mailbox!

We invite you to register for the online provider submission portal, designed by Smart Data Solutions, Inc. ("SDS"), an independent company and our business associate. Once registered, you can electronically submit documents via the Virtual Mailbox as an alternative to mailing paper items to our PO Box in Eagan, MN. Visit our website for more information. As our business associate, SDS is bound by the terms and conditions of a business associate agreement executed by Univera Healthcare. In accordance with the business associate agreement and the Health Insurance Portability and Accountability Act (HIPAA), SDS is required to maintain the confidentiality of any protected health information they receive from you on our behalf.

Dental Record Submission

We have a *Procedure Codes that Require Dental Record Submission* grid available on our website that includes information on the records needed for each procedure code listed. We recommend reviewing this grid prior to submitting claims so you can include any required dental records when you submit the claim.

Submitting a Claim for Accidental Injury

Services for the treatment of accidental injury to sound and natural teeth, when rendered within 12 months of the date of injury, are eligible for coverage in accordance with the benefits set forth in the member's medical (not dental) contract, provided the following criteria are satisfied:

- The tooth must be sound and natural with no restorative treatment and no disease prior to the injury. Note: This coverage does not extend to teeth that are broken while biting into food.

- Use the 2012 American Dental Association claim form and ADA codes
  - Box 34A should include the diagnosis code if known
  - Box 35 should say Accidental or Congenital Anomaly if the diagnosis code is unknown
  - Box 38 should include Place of Service
  - Box 45 should have Other Accident or Auto Accident checked.
  - Box 46 should include a date of the accident

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-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ______ B ______ C ______ D ______

31a. Other Fee(s)

32. Total Fee

35. Remarks
Accidental or Congenital Anomaly (if diagnosis code is unknown)

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

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

Submitting a Claim for Congenital Anomaly

Services for the treatment of Congenital Anomaly are eligible for coverage in accordance with the benefits set forth in the member's medical (not dental) contract.

Use the American Dental Association claim form and ADA codes.

- Box 34A should include the diagnosis code if known
- Box 35 should say Congenital Anomaly if the diagnosis code is unknown
- Box 38 should include Place of Service
- Box 45 should have the Occupational Illness/Injury box checked

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) (Primary diagnosis in "A") A C B D

31a. Other Fee(s)

32. Total Fee $0.00

35. Remarks
Congenital Anomaly

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

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

Submitting a Claim for Oral Sleep Apnea

Our participating dental provider contract includes participation for medical accidental injury medical and oral sleep apnea. Review Corporate Medical Policy 1.01.07, Oral Appliances for the Treatment of Sleep- Related Breathing Disorders. To help ensure that oral sleep apnea claims are submitted accurately to allow for timely payment, these claims need to be submitted on a medical claim form. Please review our Tips for Completing the CMS-1500 Claim Form and access the National Uniform Claim Committee's (NUCC) 1500 Health Insurance Claim Form Reference Instruction Manual, which is available at www.nucc.org.

Please see the Appendix for a sample CMS-1500 claim form.

Claim Payments and Remittances

Participating Providers - InstaMed®

Thank you to those participating practices that have registered for electronic fund transfer (EFT) and electronic remittance advice (ERA) through InstaMed®, an independent company retained by Univera Healthcare. If you are still receiving paper payments and remittances, we encourage you to transition to EFT/ERAs as soon as possible. Visit www.instamed.com or call 1-866-467-8263 for more information.

InstaMed advantages include:

- Accelerated payments with direct deposit into your existing bank account
- Saved time and money due to the elimination of paper checks and remittances
- Receipt of fully reconciled remittances electronically
- Access to payment details 24 hours a day, seven days a week, with the capability to view and print
- Remittance statements to help you update your billing records

Non-Participating Providers - Zelis® Payments

Univera Healthcare has partnered with Zelis® Payments, an independent company, to offer ePayment options that can accelerate the settlement of claim payments. This service is available for non-participating providers for all lines of business.

Zelis Payments' solutions are designed to:

- Accelerate payment - Receive payment by up to 20 days faster than by paper check
- Receive clean and compliant 835s and Explanations of Payment (EOPs)
- Reduce risk – electronic payments are more secure, traceable, and monitored
- Combine payments from multiple payers and decrease paperwork
- Lower expenses - decrease lockbox and bank fees
- Increase accuracy - detailed data helps you balance more accurately

Paper checks are now issued by Zelis Payments. If you are interested in transitioning to:

- ERA/EFT – Participating providers review the InstaMed information above.
- Zelis ACH or Virtual Card* - Visit zelispayments.com and click "For Healthcare Providers" to enroll.

*Important: There is a fee and required contract with Zelis Payments associated with the ACH payment method. Please contact Zelis Payments for more information. For Zelis Virtual Card, standard credit card fees apply.

Auto Recovery Payment Process

Claim overpayment (negative balance) recoveries resulting from claim overpayment adjustments are recovered by the health plan through the auto recovery process. The auto recovery process identifies when there is an outstanding negative balance due to the Health Plan and automatically reduces the provider claim payment to close the receivable. The resultant claim payment is the net of all current claim funds due and the outstanding negative balance. Refer to the Overpayment Procedures area of our website for more information.

Alternate Benefits Provision

In most cases, our subscriber contracts provide for an alternate benefit allowance for covered procedures.

When the alternate benefit allowance is provided for, and there is more than one technique or material type for a dental procedure, the dental plan will reimburse for the technique or material type that has the lesser allowance. The member and dentist should discuss which treatment is best suited for the patient and may proceed with the original treatment plan regardless of the benefit determination. If the technique or material type with the greater allowance is chosen, the member is liable for the balance between the amount of the lesser allowance and the billed amount.

Dental Claim Adjustment

When submitting the Dental Claim Adjustment Form through the mail or electronically via the SDS Portal, be sure to include the other carrier explanation of benefits for a claim that denied for other carrier information.

A corrected claim must be included for any changes to the original billed claim, including:

- Procedure code changes
- Change in patient information
- Change in charges
- Any change in provider information

Coordination of Benefits

Coordination of benefits (COB) is a provision in a contract that applies when a member is covered by more than one group health insurance carrier. COB relies on the exchange of information between carriers so that no more than 100% of the provider charge or company allowance is paid.

Adjudication Date

The payment date is required to process a COB secondary claim. You can use the payment date from your provider remittance as the adjudication date to pass on to the secondary carrier with the explanation of benefits.

Providers using InstaMed®: Use the Payment Date located on page 1 of your remittance.
Providers using Zelis® Payments: Use the Paid Date located on page 2 of your remittance

Pre-Treatment Estimate

Getting a pre-treatment estimate, or pre-determination, is a standard component of the dental insurance process. For certain services, a pre-treatment estimate must be submitted to the Health Plan so that a determination of coverage can be made before services are rendered.

It is recommended that you get a pre-treatment estimate for the following services:

- Multiple crowns
- Inlays
- Bridgework
- Partial dentures
- Labial veneers
- Dental prostheses

Dental Pre-Determination Procedure

Submit the claim form with the pre-determination box checked and omit the date of service. Along with the claim form, submit X-rays, diagnostic materials, or a narrative, when appropriate.

Submitting X-Rays

You must submit X-rays for the following services:

- Anterior crowns
- Veneers
- Multiple crowns
- Bridges
- Crown lengthening
- Difficult extractions

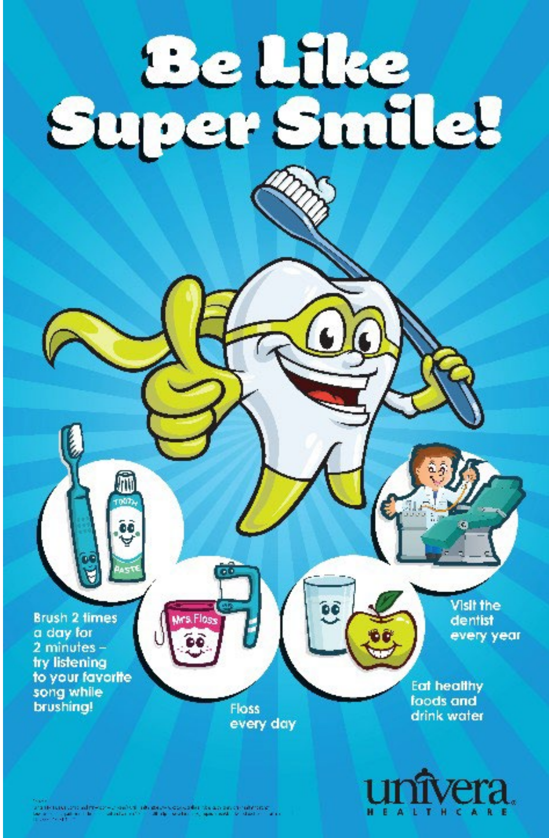
Dental Policies

Visit UniveraHealthcare.com to view the dental policies listed below:

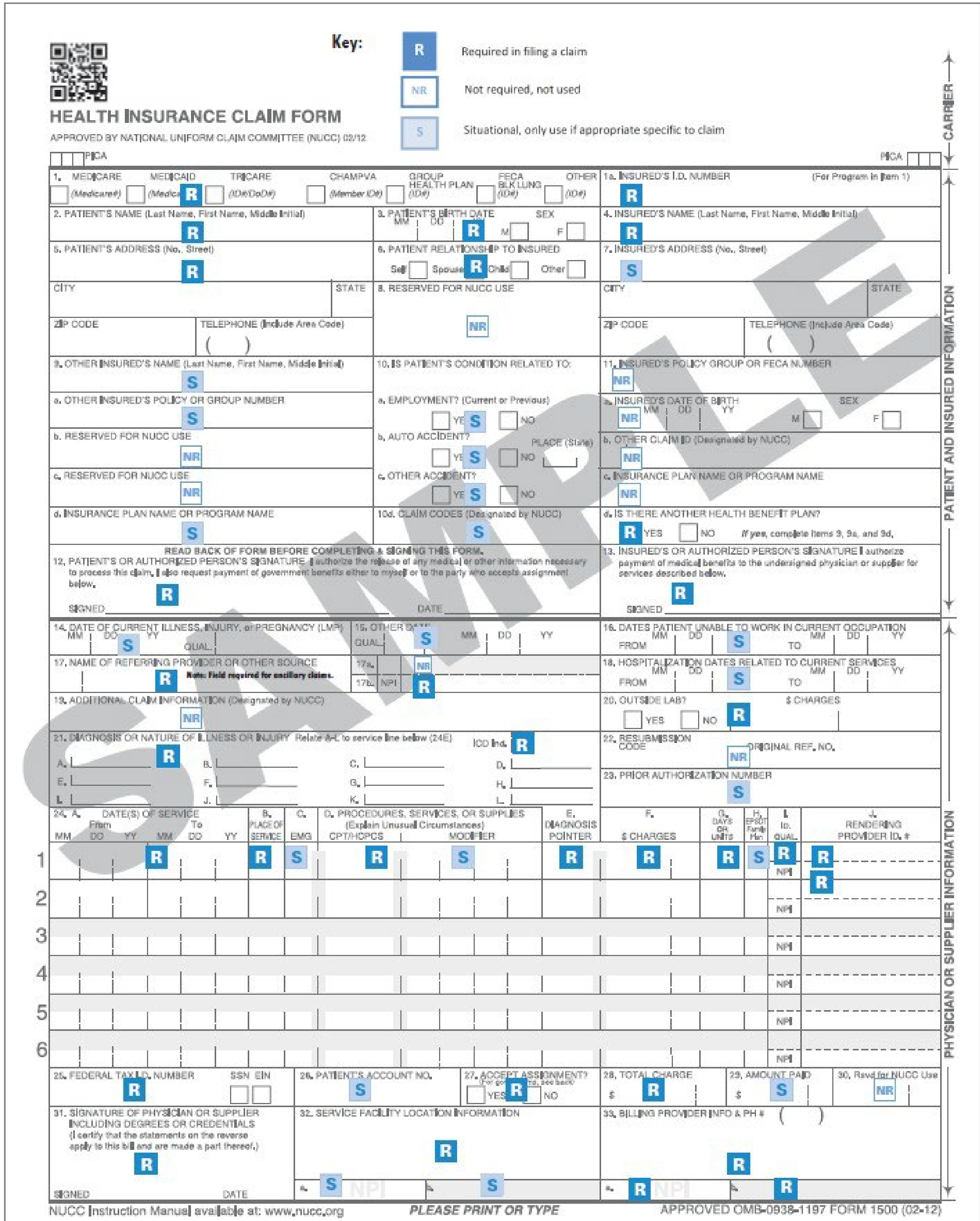
7.01.21, Dental and Oral Care under Medical Plan: Bone Cysts, Odontogenic Cysts, Oral Surgery
13.01.01, Dental Implants
13.01.02, Dental Crowns and Veneers
13.01.03, Dental Inlays and Onlays
13.01.04, Periodontal Scaling and Root Planing
13.01.05, Periodontal Maintenance

Participating Providers - Pediatric Dental Poster

Children's Oral Health poster, available for order! Contact your Provider Relations representative for more information.



CMS 1500 Claim Form Sample



Key:
- R — Required in filling a claim
- NR — Not required, not used
- S — Situational, only use if appropriate specific to claim

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) R TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) R

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

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

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

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED Self Spouse R Child Other

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE NR

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) S

a. OTHER INSURED'S POLICY OR GROUP NUMBER S

b. RESERVED FOR NUCC USE NR

c. RESERVED FOR NUCC USE NR

d. INSURANCE PLAN NAME OR PROGRAM NAME S

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? YES S NO

10d. CLAIM CODES (Designated by NUCC) S

11. INSURED'S POLICY GROUP OR FECA NUMBER NR

a. INSURED'S DATE OF BIRTH MM DD YY NR SEX M F

b. OTHER CLAIM ID (Designated by NUCC) NR

c. INSURANCE PLAN NAME OR PROGRAM NAME NR

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? R 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 R DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED R

PHYSICIAN OR SUPPLIER INFORMATION

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

15. OTHER DATE QUAL. S MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE R **Note: Field required for ancillary claims.**

17a. NR

17b. NPI R

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NR

20. OUTSIDE LAB? YES NO R $ CHARGES

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

A. R B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE NR ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER S

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 R	R	S	R	S	R	R	R	S	R / NPI	R / R
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

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

26. PATIENT'S ACCOUNT NO. S

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES R NO

28. TOTAL CHARGE $ R

29. AMOUNT PAID $ S

30. Rsvd for NUCC Use NR

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.) R

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION R

a. S NPI b. S

33. BILLING PROVIDER INFO & PH # ( ) R

a. R NPI b. R

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

SAMPLE

Key: "R" - Required in filing a claim
"NR" - Not required, not used
"S" - Situational, only used if appropriate specific to claim

1. TYPE OF HEALTH INSURANCE COVERAGE [R]
Select "Other"

1A. INSURED ID NUMBER [R]
Enter the subscriber's identification number **and three-character prefix required.**

2. PATIENT'S NAME [R] Last name, First name, Middle initial
Enter the patient's last name, first name and middle initial

3. PATIENT'S BIRTH DATE/SEX [R]
Enter the patient's date of birth using the eight-digit date format (MM/DD/CCYY)
Next, select the patient's gender

4. INSURED'S NAME [R] Last name, First name, Middle initial
Enter the insured's last name, first name and middle initial

5. PATIENT'S ADDRESS/TELEPHONE NUMBER [R]
Enter the patient's permanent mailing address and telephone number

6. PATIENT'S RELATIONSHIP TO THE INSURED [R] Note - If the patient is not the subscriber, do not select "Self"
Select the appropriate box for patient's relationship to the insured person

7. INSURED'S ADDRESS/TELEPHONE NUMBER [S]
Enter the insured person's permanent mailing address (complete if different from the patient's address)

8. RESERVED FOR NUCC USE [NR]

9. OTHER INSURED'S NAME [S]
Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.

9A. OTHER INSURED'S POLICY OR GROUP NUMBER [S]
Enter the other insured person's policy or group number **- field is very important for COB claims**

9B. RESERVED FOR NUCC USE [NR]

9C. RESERVED FOR NUCC USE [NR]

9D. INSURANCE PLAN NAME OR PROGRAM NAME [S]
Enter the name of the other insured person's insurance plan or program name

10A-D. IS PATIENT'S CONDITION RELATED TO:
For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank

10A. Select whether the patient's condition is related to employment [S]

10B. Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation [S]

10C. Select whether the patient's condition is related to any other type of accident [S]

10D. CLAIM CODES (DESIGNATED BY NUCC) [S]

(11 thru 11d, refer to subscriber coverage)

11. INSURED'S POLICY GROUP OR FECA NUMBER [NR]
Enter the subscriber's group number

11A. INSURED'S DATE OF BIRTH, SEX [NR]
Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender

11B. OTHER CLAIM ID (DESIGNATED BY NUCC) [NR]

11C. INSURANCE PLAN NAME OR PROGRAM NAME [NR]
Enter the subscriber's insurance plan name, include name of state

11D. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN [R]
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE [R]
Enter the phrase SIGNATURE ON FILE, or include legal signature (and date) of patient or authorized person.

13. INSURED OR AUTHORIZED PERSON'S SIGNATURE [R] **Enter the phrase SIGNATURE ON FILE, or include legal signature (and date) of patient or authorized person. If neither, leave blank or state no signature on file.**

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) [S]
Enter the date using an eight-digit date format (MM/DD/CCYY)

15. OTHER DATE [S]
Enter the date using an eight-digit date format (MM/DD/CCYY) **Need qualifier, see NUCC manual**

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION [S]
Enter the date using an eight-digit date format (MM/DD/CCYY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [R] **NOTE - Field required for Ancillary claims**
Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required only if there is a referring, ordering or supervising provider.

17A. OTHER ID# [NR]
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier)

17B. NPI # [R]
Enter the 10-digit NPI number of the referring, ordering or supervising provider

18. HOSPITAL DATES RELATED TO CURRENT SERVICES [S]
Enter the hospital dates using an eight-digit date format (MM/DD/CCYY)

19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC) [NR]
Not required

20. OUTSIDE LAB/CHARGES [R]
Select "Yes" or "No" to indicate if the claim includes charges for lab services performed outside of the physician's office. If Yes," enter the total charges.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY [R]
Enter the ICD-CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. **Up to 11 additional ICD-CM codes can be entered. ICD Ind. required.**

22. RESUBMISSION [NR]
Not required

23. PRIOR AUTHORIZATION NUMBER [S]
Not required

24. SHADED AREA – SUPPLEMENTAL INFORMATION –
The shaded area of field 24a - 24h was created to accommodate supplemental information **(i.e., NDC)**
For more information, see the National Uniform Claim Committee's Website at www.nucc.org.

24A. DATE(S) OF SERVICE [R]
Enter the dates of service using an eight-digit date format (MM/DD/CCYY) **Note - Cannot be a future date.**

24B. PLACE OF SERVICE [R]
Enter the appropriate two-digit Place of Service code

24C. EMG [S]
If this service was an emergency, enter "Y" for "Yes," or leave blank if "No"

24D. PROCEDURES, SERVICES, OR SUPPLIES [R]
Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable

24E. DIAGNOSIS POINTER [R]
Enter the appropriate ICD-CM diagnosis code or codes for each procedure performed. Enter one code per line of service. **Note - Use alpha (A-L), not numeric.**

24F. CHARGES [R]
Enter the charge for each line of service. **Note - Do not include discounts/negative amounts.**

24G. DAYS OR UNITS [R]
Enter the number of days or units for each line of service

24H. EPSDT/FAMILY PLAN [S]
If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code

24I. ID QUALIFIER - SHADED FIELD [R]
reserved for taxonomy code qualifier, "ZZ"

24J. RENDERING PROVIDER ID. # [R] **Note - Required for Group Practices.**
SHADED FIELD
reserved for taxonomy code

NON-SHADED FIELD [R]
Enter the performing provider's 10-digit NPI number in the non-shaded area

25. FEDERAL TAX I.D. NUMBER [R]
Enter the Federal Tax I.D. Number for the provider of service. Select the appropriate field for SSN or EIN.

26. PATIENT ACCOUNT NUMBER [S]
Enter account number assigned to the patient, if applicable

27. ACCEPT ASSIGNMENT [R]
Select "Yes" **Note - Only if the provider participates with Univera Healthcare.**

28. TOTAL CHARGE [R] **Note - If multiple pages, put total on last page only.**
Enter the total charge for all services (total of all charges in 24f)

29. AMOUNT PAID [S]
Enter the amount paid by the patient or other payers on covered services only.

30. RSVD FOR NUCC USE [NR]

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS [R]
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY). **Should match rendering provider signature - field 24J**

32. SERVICE FACILITY LOCATION INFORMATION [R] **Note - Required when different from Billing Provider.**
Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.

Note: Per the NUCC Instruction Manual, Field 32 is required if Field 20 is checked "yes."
For more information, see the National Uniform Claim Committee's Website at www.nucc.org.

32A. NPI [S]
Enter the 10-digit NPI number of the service facility location

32B. OTHER ID# [S]
reserved for taxonomy code **- including ZZ qualifier**

33. BILLING PROVIDER INFO AND PH# [R] **Note - Provide physical address in this field.**
Enter the information of the billing provider or supplier to be paid for services

33A. NPI [R]
Enter the 10-digit NPI number of the billing provider

33B. OTHER ID # [R] **Note - Required for Individual/Solo Practices.**
reserved for taxonomy code**- including ZZ qualifier**

Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

For additional information on Place of Service Codes visit:
http://www.cms.gov/Medicare/Coding/place-of-service-codes/

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

- 7 Anesthesia information
- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)
- VP Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard
- OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
- CTR Contract rate

For additional information for reporting NDC units, see the National Uniform Claim Committee's website at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's prefix and identification number in Field 1a.
- Put the physician or supplier's billing name, address, zip code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

For information on submitting claims electronically, visit:
https://www.lifethc.com/vendors/consentforms.html