

# CMS-1500 Form User Guide for Professional Providers

This guide will help you complete the CMS-1500 (Version 02/12) form when submitting claims to Blue Cross and Blue Shield of Oklahoma.

### Mail Paper Commercial Claims to:

Blue Cross and Blue Shield of Oklahoma P.O. Box 655924 Dallas, TX 75265-5924

### Mail Initial Paper Medicare Claims to:

Blue Cross Medicare Advantage C/O Claims Department PO Box 3686 Scranton, PA 18505 To learn more about the CMS-1500 form, see the National <u>Uniform Claim</u> <u>Committee's</u> <u>instruction manual</u>.

### **Electronic Claim Submission Is Preferred**

Please only submit paper claims if necessary. Electronic claim submission is preferred on <u>Availity® Essentials</u>. For more information, visit our <u>Claim Tips webpage</u> and select the **Electronic Claims** section.

### **To Order CMS-1500 Forms**

- Visit the U.S. Government Bookstore, or
- Call the U.S. Government Printing Office at 1-866-512-1800

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSOK. BCBSOK makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



### **HEALTH INSURANCE CLAIM FORM**

EALTH INSURA	NCE CLAIM	FORM								
PROVED BY NATIONAL UNI										
PICA									PICA	
MEDICARE MEDICA	D TRICARE	CHAMPV	A GROUP		OTHER	1a. INSURED'S I.D. NUMB	ER	(Fo	Program in Item 1)	
(Medicare#) (Medica	R (ID#/DoD#)	(Member II	$D#) \square (ID#)$		(ID#)	R				
PATIENT'S NAME (Last Nam	e, First Name, Middle Init R	ial)	3. PATIENT'S BIRTH	R M	F	4. INSURED'S NAME (Las	t Name, First N	ame, Middle	e Initial)	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)				
	R		Self Spouse	R Child (	Other	S				
ΤΥ		STATE	8. RESERVED FOR N	UCC USE		CITY			STATE	
P CODE	TELEPHONE (Include	Area Code)				ZIP CODE			ude Area Code)	
FOODE		Alea Coue)	Ľ	NR		ZIF CODE	(		ude Alea Code)	
OTHER INSURED'S NAME (	ast Name First Name N	/iddle Initial)	10. IS PATIENT'S CO		D TO:	11. INSURED'S POLICY G			3	
	S	nddie Initial)	_			R	NOUP ON FEC			
OTHER INSURED'S POLICY			a. EMPLOYMENT? (C	urrent or Previous	)	a. INSURED'S DATE OF B	IRTH YY		SEX	
	S			S NO		R		M	F	
RESERVED FOR NUCC US	_		b. AUTO ACCIDENT?		ACE (State)	b. OTHER CLAIM ID (Desi	gnated by NUC	CC)		
L	IR		c. OTHER ACCIDENT							
RESERVED FOR NUCC USE							C. INSURANCE PLAN NAME OR PROGRAM NAME			
NSURANCE PLAN NAME O			10d. CLAIM CODES (I		CC)	d. IS THERE ANOTHER H	EALTH BENEF	TT PLAN?		
	s			<b>IR</b>		R YES NO			is 9, 9a, and 9d.	
REAL	BACK OF FORM BEFO	DRE COMPLETING	& SIGNING THIS FOR	IM.		13. INSURED'S OR AUTH		-		
PATIENT'S OR AUTHORIZE to process this claim. I also re						payment of medical ber services described belo		lersigned ph	iysician or supplier for	
below.	IR					NR				
SIGNED			DATE			SIGNED				
	SS, INJURY, or PREGNA	NCY (LMP) 15.			Υ	16. DATES PATIENT UNA MM   DD	BLE TO WORK	IN CURRE	NT OCCUPATION	
	QUAL.	QU				FROM	5	ТО		
NAME OF REFERRING PR	OVIDER OR OTHER SOU					18. HOSPITALIZATION DA		MM	ENT SERVICES	
ADDITIONAL CLAIM INFOR			NPI S			FROM 1 1	9	TO \$ CHARG		
	IR	NUCC)					NR	⇒ CHANG		
DIAGNOSIS OR NATURE C		Relate A-L to serv	ice line below (24E)							
R		-		ICD Ind.		22. RESUBMISSION CODE	PRIGIN	IAL REF. NO	Э.	
	В.	_ C. L		D		23. PRIOR AUTHORIZATI	ON NUMBER			
	F.	_ G. L K.		н			NR			
A. DATE(S) OF SERVI			DURES, SERVICES, O	R SUPPLIES	E.	F.	G. H.	l	J.	
From DD YY MM	TO PLACE OF DD YY SERVICE	EMG CPT/HCP	ain Unusual Circumstanc CS   MOD	es) IFIER	DIAGNOSIS POINTER	\$ CHARGES U		ID. QUAL.	RENDERING PROVIDER ID. #	
R	R	S	RS		R	R	RS		]	
	i			i l				NPT R		
								NPI		
								NPI		
i i l i	<u>    i    l     l      l               </u>							VE I		
								NPI		
					_			NPI		
1 1 1 1	1			1 1 1						
		OC DATICNESS			NMENTO				20 Poud for NULCO	
. FEDERAL TAX I.D. NUMBE	R SSNEIN	26. PATIENT'S A	CCOUNTINO. 2	7. ACCEPT ASSIC		28. TOTAL CHARGE	29. AMOUN		30. Rsvd for NUCC	
SIGNATURE OF PHYSICIA					NO	\$ 1 33. BILLING PROVIDER IN	Ψ.			
INCLUDING DEGREES OR	CREDENTIALS	C. CENVICE FA					ποαrπ#	( )		
(I certify that the statements apply to this bill and are mad	e a part thereof.)									
R			S				R			
	D	a. <b>S</b> NI	b.	NR		a. R NP	b.	5		
GNED	DATE			RINT OR TY		APPROVE				

# KEY

**R** REQUIRED IN FILING A BLUE CROSS CLAIM

S SITUATIONAL – ONLY IF APPROPRIATE TO THIS CLAIM

NR NOT REQUIRED/NOT USED

<ul> <li>occurred. Use two-character abbreviation, i.e. OK. S</li> <li>Select whether the patient's condition is related to any other type of accident. S</li> <li>CLAIM CODES (DESIGNATED BY NUCC) C</li> <li>(11 thru 11d, refer to BCBS subscriber coverage)</li> <li>INSURED'S POLICY GROUP OR FECA NUMBER C</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX C</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX C</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX C</li> <li>Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) C</li> <li>Enter the subscriber's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME C</li> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>ISTHERE ANOTHER HEALTH INSURANCE BENEFIT PLAN C</li> <li>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.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE </li> <li>Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE </li> <li>Not required in filing BCBS claims.</li> <li>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) C</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE S</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> </ul>	1a.	Select "Other" to indicate that you are submitting a Blue Cross and Blue Shield Plan claim. INSURED ID NUMBER R					
<ul> <li>Enter the patient's latent name, first name and middle initial.</li> <li><b>PATIENT'S BIRTH DATE/SEX (2)</b></li> <li>Enter the patient's date of brith using the eight-digit date format (MAVDD/CCYY). Next, select the patient's gender.</li> <li><b>INSURED'S NAME (2)</b> act name, First name and middle initial Enter the patient's permanet name, first name and middle initial.</li> <li><b>PATIENT'S ADDRESS/TELEPHONE NUMBER (2)</b></li> <li>Enter the patient's permanet namling address at delphone number.</li> <li><b>PATIENT'S RELATIONSHIP TO THE INSURED (2)</b></li> <li>Select the appropriate box for patient's relationship to the insured person.</li> <li><b>INSURED'S ADDRESS/TELEPHONE NUMBER (3)</b></li> <li>Enter the patient's permanet namling address and telphone number.</li> <li><b>PATIENT'S RELATIONSHIP TO THE INSURED (3)</b></li> <li><b>Select the appropriate box for patient's relationship to the insured person's permanet: maling address and telphone number.</b></li> <li><b>INSURED'S ADDRESS/TELEPHONE NUMBER (3)</b></li> <li>Enter the other insured person's last name, first name and middle initial. When the patient's address) to coordinate benefits with other insurance companies.</li> <li><b>OTHER INSURED'S POLICY OR GROUP NUMBER (3)</b></li> <li>Enter the other insured person's balloy or group number.</li> <li><b>RESERVED FOR NUCC USE (3)</b></li> <li>Enter the other insured person's singloyer or school name.</li> <li><b>INSURANCE PLAN NAME OR PROGRAM NAME (5)</b></li> <li>Enter the other insured person's singloyer or school name.</li> <li><b>INSURANCE PLAN NAME OR PROGRAM NAME (5)</b></li> <li>Enter the other insured person's singlingen or school name.</li> <li><b>INSURED'S CONDITION RELATED TO:</b></li> <li>For 10a - 10d, required status is contingent upon a definitive Yes' or 'No' answer. If you are unsure, leave blank.</li> <li><b>Select whether the patient's condition is related to any other type of accident. (5)</b></li> <li><b>Select whether the patient's condition is related to any other type of accident. (5)</b></li> <li><b>Select whether the patient's condition is r</b></li></ul>							
Enter the patient's due of kinn using the eight digit date format (MM/DD/CCVY). Next, select the patient's gender: 4. INSURED'S NAME IS Las name, First name, Middle Initial Enter the insured's last name, first name and middle initial. 5. PATIENT'S RELATIONSHIP TO THE INSURED IS Select the appropriate box for patients' relationship to the insured person. 7. INSURED'S ADDRESS/TELEPHONE NUMBER IS Enter the insured person's permanent maining address (complete if different from the patient's address) 8. RESERVED FOR NUCC USE IS 9. OTHER INSURED'S POLICY OR GROUP NUMBER IS Enter the other insured person's last name, first name and middle initial. When the patient has other insurance correage, ovel mide to complete fields 9 at through 9d. This information is necessary to coordinate benefits with other insurance companies. 9. OTHER INSURED'S POLICY OR GROUP NUMBER IS Enter the other insured persons's date of birth in an eight-digit date format (MM/DD/CCY). 5. RESERVED FOR NUCC USE IS Enter the other insured persons's employer or school name. 91. INSURANCE PLAN NAME OR ROGEAM NAME IS Enter the other insured persons's memory or oschool name. 92. INSURANCE PLAN NAME OR ROGEAM NAME IS Enter the other insured persons's insurance plan or program name. 10. Select Whether the patient's condition is related to an auto accident and enter the state in which the accident 10. Select Whether the patient's condition is related to any other type of accident. IS 10. Select Nether the patient's condition is related to any other type of accident. IS 10. Select Nether the patient's condition is related to any other type of accident. IS 10. Subtro SOLICY GROUP OR FECA NUMBER IS Enter the subscriber's genoup mome from there REGIS ID card. 11. INSURED'S DUCCY GROUP OR PEGA NUMARE IS Enter the subscriber's due of birth using the eight-digit date format (MM/DD/CCY), and select the subscriber's employer or school name. 11. INSURED'S POLICY CROUP OR PEGA NUMARE IS Enter the data using an eight-digit date format (MM	2.						
<ul> <li>Next, select the patient's gender.</li> <li>Next, select the patient's gender.</li> <li>NUSRED'S ANME is Last name, First name, Middle initial Enter the insured's last name, first name and middle initial.</li> <li>PATIENT'S ADDRESS/TELEPHONE NUMBER is Enter the patient's permanent mailing address and telephone number.</li> <li>NUSRED'S ADDRESS/TELEPHONE NUMBER is Enter the insured person's permanent mailing address (complete if different from the patient's address) Enter the insured person's permanent mailing address (complete if different from the patient's address)</li> <li>RESERVED FOR NUCC USE is</li> <li>OTHER INSURED'S NAME is</li> <li>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 benfis with other insurance companels.</li> <li>OTHER INSURED'S POLICY OR GROUP NUMBER is</li> <li>Enter the other insured person's batic or group number.</li> <li>RESERVED FOR NUCC USE is</li> <li>Enter the other insured person's stat and engitt-digit date format (MM/DD/CCY).</li> <li>RESERVED FOR NUCC USE is</li> <li>Enter the name of the other insured person's memolyer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME is</li> <li>Enter the name of the other insured person's insurance plan or program name.</li> <li>IS PATIENT'S CONDITION RELATED TO: For 10a – 10d, required status is contingent upon a definitive Yes' or 'No' answer. If you are unsure, lease blank.</li> <li>Select whether the patient's condition is related to any other type of accident.</li> <li>Select whether the patient's condition is related to any other type of accident.</li> <li>Select whether the patient's condition is related to any other type of accident.</li> <li>Select whether the patient's condition is related to any other type of accident.</li> <li>Select whether the patient's dubre withou, u.e. OK is</li> <li>C LAIM CODES (DESIGNATED BY NUCC) is</li> <li>C THER DAF</li></ul>	3.						
Enter the insured's last name, first name and middle initial. PATIENT'S ADDRESS/TELEPHONE NUMBER IS Enter the patient's permanent mailing address and telephone number. NINSURED'S ADDRESS/TELEPHONE NUMBER IS Enter the insured person's permanent mailing address (complete if different from the patient's address) RESERVED FOR NUCC USE IM OTHER INSURED'S NAME IS 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 field so through 9d. This information is necessary to coordinate benefits with other insurance persongenes. RESERVED FOR NUCC USE IM RESERVED FOR NUCC USE IM 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 field so through 9d. This information is necessary to coordinate benefits with other insurance companies. RESERVED FOR NUCC USE IM 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 field so through 9d. This information is necessary to coordinate benefits with other insured person's insurance pane on program name. Enter the other insured person's insurance plan or program name. Insure the other insured person's insurance plan or program name. Insure the name of the other insured person's insurance plan or program name. Insure the name of the other insured person's insurance plan or program name. Insure the patient's condition is related to any other type of accident. Implement of the other insured person's insurance plan or they advect the state in which the acciden occurred. Use two-character abbrekiation, i.e. OK, Im CLAIM CODES (DESIGNATED BY NUCC) Im (If thru 11d, refer to EGS subscinder coverage) InsureD'S DATE OF INTER, SEX Im Enter the subscriber's gender. Implement the subscriber's gender. Implement the other insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahome Implement th							
5. PATIENT'S ADDRESS/TELEPHONE NUMBER  Center the patient's permanent mailing address and telephone number. 6. PATIENT'S RELATIONSHIP TO THE INSURED  Select the appropriate box for patient's relationship to the insured person. 7. INSURED'S ADDRESS/TELEPHONE NUMBER  Enter the insured person's permanent mailing address (complete if different from the patient's address) 8. RESERVED FOR NUCC USE  9. OTHER INSURED'S NAME  9. OTHER INSURED'S NAME  9. OTHER INSURED'S NAME  9. OTHER INSURED'S OLICY OR GOUP NUMBER  9. RESERVED FOR NUCC USE  9. OTHER INSURED'S OLICY OR GOUP NUMBER  9. RESERVED FOR NUCC USE  9	4.						
	5.	PATIENT'S ADDRESS/TELEPHONE NUMBER R					
7. INSURED'S ADDRESS/TELEPHONE NUMBER S Enter the insured person's permanent malling address (complete if different from the patient's address) 8. RESERVED FOR NUCC USE S OTHER INSURED'S NAME S Enter the other insured person's bar 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 compaties. 9. OTHER INSURED'S NAME S Enter the other insured person's data for thirth an eight-digit data format (MM/DD/CCY). 9. RESERVED FOR NUCC USE S Enter the other insured person's employer or school name. 9. INSURANCE PLAN NAME OR PROGRAM NAME S Enter the other insured person's employer or school name. 9. INSURANCE PLAN NAME OR PROGRAM NAME S Enter the name of the other insured person's insurance plan or program name. 10. IS PATIENT'S CONDITION RELATED TO: 10. For 10a - 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, 10. Select whether the patient's condition is related to any other type of accident. 11. Oncess (DESEGNATED BY NUCC) 12. Select whether the patient's condition is related to any auto accident and enter the state in which the acciden 12. Select whether the patient's condition is related to any other type of accident. 13. INSURED'S POLICY GROUP OR FECA NUMBER C 14. INSURED'S POLICY GROUP OR FECA NUMBER C 15. There the subscriber's group number from their BCBS ID card. 14. INSURED'S ADLE OF BITH, SX 12 Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCY) and select the subscriber's gender. 14. INSURED'S ADLE OF BY NUCC) 15. OTHER CLAIM ID (DESIGNATED BY NUCC) 16. DATEE AND MARE OR PROGRAM NAME C 17. INSURED'S ADLE OF BITH, SX 12 Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCY) and select the subscriber's gender. 14. INSURED'S ADLE OF BY NUCC) 15. OTHER CLAIM ID (DESIGNATED BY NUCC) 16. DATEER AND MARE OR PROGRAM NAME C 17. INSURED'S CLAIM ID (DESIGNATED BY	6.						
<ul> <li>Enter the insured person's permanent mailing address (complete if different from the patient's address)</li> <li>RESERVED FOR NUCC USE [**]</li> <li>OTHER INSURED'S NAME [*]</li> <li>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 9 athrough 9d. This information is necessary to coordinate benefits with other insurance companies.</li> <li>OTHER INSURED'S POLCY OR GROUP NUMBER [*]</li> <li>Enter the other insured person's paidy or group number.</li> <li>RESERVED FOR NUCC USE [**]</li> <li>Enter the other insured person's employer or school name.</li> <li>HONSURANCE PLAN NAME OR PROGRAM NAME [\$]</li> <li>Enter the other insured person's employer or school name.</li> <li>INSURED'S POLICY OR RELATED TO:</li> <li>For 10a - 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.</li> <li>Select whether the patient's condition is related to any other type of accident. [\$]</li> <li>Select whether the patient's condition is related to any other type of accident. [\$]</li> <li>CLAIM CODES (DESIGNATED BY NUCC) [**]</li> <li>(11 thur 11d, refer to BCBS subscriber overage)</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]</li> <li>Enter the subscriber's group number flom their BCBS ID card.</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]</li> <li>Enter the subscriber's group number flom their BCBS ID card.</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]</li> <li>Enter the subscriber's group number flom their BCBS ID card.</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]</li> <li>Enter the subscriber's group number flom their BCBS ID card.</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]</li> <li>Enter the subscriber's adde of birth using the eight-digit date format (MM/DD/CCY) and select the subscriber's group number flom their BCBS ID card.</li> <li>INSURED'S DALE OF BIRTH, SEX [\$]<td></td><td></td></li></ul>							
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. 93. OTHER INSURED'S POLICY OR GROUP NUMBER S Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY). 94. RESERVED FOR NUCC USE S Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY). 95. RESERVED FOR NUCC USE S Enter the other insured person's memory or school name. 96. INSURANCE PLAN NAME OR PROGRAM NAME S Enter the other insured person's insurance plan or program name. 110. Select whether the patient's condition is related to any other Yes" or "No" answer. If you are unsure, leave blank. 104. Select whether the patient's condition is related to any other type of accident. 105. Select whether the patient's condition is related to any other type of accident. 106. Select whether the patient's condition is related to any other type of accident. 107. Select Whether the patient's condition is related to any other type of accident. 108. CLAIM CODES (DESIGNATED BY NUCC)  109. Select whether the patient's condition is related to any other type of accident. 109. Select whether the patient's condition is related to any other type of accident. 100. Select Whether the patient's condition is related to any other type of accident. 101. INSURED'S POLICY GROUP OR FECA NUMBER R Enter the subscriber's group number from their BCBS ID card. 118. INSURED'S DATE OF BIRTH, SEX R Enter the subscriber's group number from their BCBS ID card. 118. INSURED'S DATE OF BIRTH, SEX R Enter the subscriber's group number from their BCBS ID card. 119. OTHER CLAIM ID (DESIGNATED BY NUCC)  110. THER CLAIM ID (DESIGNATED BY NUCC)  121. INSURACE PLAN NAME OR PROGRAM NAME R Enter the subscriber's group number from their BCBS ID card. 113. INSURACE PLAN NAME OR PROGRAM NAME R Enter the subscribe's dact	7.						
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  Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY). 9c. RESERVED FOR NUCC USE  Patter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY). 9c. RESERVED FOR NUCC USE  Patter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY). 9c. RESERVED FOR NUCC USE  Patter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY). 9c. RESERVED FOR NUCC USE  Patter the name of the other insured person's insurance plan or program name. 1c. ISPATIENT'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 an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. OK  10b. Select whether the patient's condition is related to any other type of accident. 11c. INSURED'S POLICY GRUP OR FECA NUMBER  11c. 11d. NSURED'S DATE OF BIRTH, SEX  11b. OTHER CLAINID (DESIGNATED BY NUCC)  11c. 11c. INSURANCE PLAN NAME OR PROGRAM NAME  11c. 11c. 11c. 11c. 11c. 11c. 11c. 11c	8.						
Enter the other insured person's policy or group number.	9.	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					
<ul> <li>Enter the other insured person's due of birth in an eight-digit date format (MM/DD/CCYY).</li> <li>Perster the other insured person's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME S</li> <li>Enter the name of the other insured person's insurance plan or program name.</li> <li>IPATIENT'S CONDITION RELATED TO: For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.</li> <li>Select whether the patient's condition is related to employment.</li> <li>Select whether the patient's condition is related to an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. (NC S)</li> <li>Celect whether the patient's condition is related to any other type of accident.</li> <li>CLAIM CODES (DESIGNATED BY NUCC) <sup>MD</sup></li> <li>(11 thru 11d, refer to BCB subscriber coverage)</li> <li>INSURED'S POLICY GROUP OR FECA NUMBER C</li> <li>Enter the subscriber's gender.</li> <li>INSURED'S DATE OF BIRTH, SEX C</li> <li>Enter the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) <sup>MD</sup></li> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME R</li> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME R</li> <li>Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete field S J9, and 9d. This information is necessary to coordinate benefits with oth insurance or mappies.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE <sup>MD</sup></li> <li>Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE <sup>MD</sup></li> <li>ADATE OF CURRENT LILLNESS, INJURY, OR PREGNANCY (LMP) <sup>MD</sup></li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>INA CO RAUTHORIZED PERSON'S SIGNATURE <sup></sup></li></ul>	9a.						
<ul> <li>Enter the other insured person's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME is Enter the name of the other insured person's insurance plan or program name.</li> <li>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.</li> <li>10a. Select whether the patient's condition is related to employment.</li> <li>10b. Select whether the patient's condition is related to an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. OK is</li> <li>10c. Select whether the patient's condition is related to any other type of accident.</li> <li>10d. CLAIM CODES (DESIGNATED BY NUCC) [Mail (11 thru 11d, refer to BCBS subscriber coverage)</li> <li>11. INSURED'S POLICY GROUP OR FECA NUMBER IS Enter the subscriber's group number from their BCBS ID card.</li> <li>11a. INSURED'S DATE OF BIRTH, SEX [Mail Enter the subscriber's date of birth using the eight-digit date format (MM//DD//CCYY) and select the subscriber's gender.</li> <li>11b. OTHER CLAIM ID (DESIGNATED BY NUCC) [Mail Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>11d. ISTHERE 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 othe insurance companies.</li> <li>12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE [Mail Not required in filing BCBS claims.</li> <li>13. INSURED OR AUTHORIZED PERSON'S SIGNATURE [Mail Not required in gaing a eight-digit date format (MM//DD/CCYY).</li> <li>14. DATE OF CURRENT ILLINESS, INJURY, OR PREGNANCY (LMP) [S] Enter the date using an eight-digit date format (MM//DD/CCYY).</li> <li>15. OTHER DATE [S] Enter the date using an eight-digit date format (MM//DD/CCYY).</li> <li>16. DATES PATIENT UNABL</li></ul>	9b.						
94.       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.         10b.       Select whether the patient's condition is related to an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. OK.         10c.       Select whether the patient's condition is related to any other type of accident.         10d.       CLAIM CODES (DESIGNATED BY NUCC) Note:         11d.       INSURED'S POLICY GROUP OR FECA NUMBER IS         11e.       INSURED'S DATE OF BIRTH, SEX IS         11e.       Enter the subscriber's group number from their BCBS ID card.         11a.       INSURED'S DATE OF BIRTH, SEX IS         11b.       OTHER CLAIM ID (DESIGNATED BY NUCC) Note:         11c.       INSURANCE PLAN NAME OR PROGRAM NAME IS         11c.       INSURANCE PLAN NAME OR PROGRAM NAME IS         11d.       ISTHERE ANOTHER HEALTH INSURANCE BEREFIT PLAN IS         11d.       ISTHERE ANOTHER HEALTH INSURANCE BEREFIT PLAN IS         11d.       ISTHERE ANOTHER HEALTH INSURANCE DERSITY PLAN IS         11d.       ISTHERE ANOTHER HEALTH INSURANCE BEREFIT PLAN IS<	9c.						
<ul> <li>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.</li> <li>10a. Select whether the patient's condition is related to employment. S</li> <li>10b. Select whether the patient's condition is related to an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. OK. S</li> <li>10c. Select whether the patient's condition is related to any other type of accident. S</li> <li>10d. CLAIM CODES (DESIGNATED BY NUCC) S</li> <li>10d. CLAIM CODES (DESIGNATED BY NUCC) S</li> <li>11. INSURED'S POLICY GROUP OR FECA NUMBER S</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>11a. INSURED'S DATE OF BIRTH, SEX S</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>11a. INSURED'S DATE OF BIRTH, SEX S</li> <li>Enter the subscriber's gender.</li> <li>11b. OTHER CLAIM ID (DESIGNATED BY NUCC) S</li> <li>Enter the subscriber's employer or school name.</li> <li>11c. INSURANCE PLAN NAME OR PROGRAM NAME S</li> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>11d. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN S</li> <li>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 othe insurance companies.</li> <li>12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE S</li> <li>Not required in filing BCBS claims.</li> <li>13. INSURED OR AUTHORIZED PERSON'S SIGNATURE S</li> <li>Not required in filing BCBS claims.</li> <li>14. DATE OF CURRENT ILLINESS, INJURY, OR PREGNANCY (LMP) S</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>15. OTHER DATE S</li> <li>DATE OF CURRENT ILLINESS, INJURY, OR PREGNANCY (LMP) S</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li></ul>	9d.	INSURANCE PLAN NAME OR PROGRAM NAME					
<ul> <li>leave blank.</li> <li>10a. Select whether the patient's condition is related to employment. S</li> <li>Select whether the patient's condition is related to an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. OK. S</li> <li>Select whether the patient's condition is related to any other type of accident. S</li> <li>10c. Select whether the patient's condition is related to any other type of accident. S</li> <li>(11 thru 11d, refer to BCBS subscriber coverage)</li> <li>11. INSURED'S POLICY GROUP OR FECA NUMBER S</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>11a. INSURED'S DATE OF BIRTH, SEX R</li> <li>Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>11b. OTHER CLAIM ID (DESIGNATED BY NUCC) </li> <li>Enter the subscriber's maployer or school name.</li> <li>11c. INSURANCE PLAN NAME OR PROGRAM NAME S</li> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>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 oth insurance companies.</li> <li>12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE </li> <li>Not required in filing BCBS claims.</li> <li>13. INSURED OR AUTHORIZED PERSON'S SIGNATURE </li> <li>Not required in filing BCBS claims.</li> <li>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) </li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>15. OTHER DATE SIGN ARC FORMER IN CURRENT OCCUPATION S</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>17. OTHER DATE SIGN OF SUPPRIVIDER OR OTHER SOURCE S</li> <li>Enter the referri</li></ul>	10a-d	IS PATIENT'S CONDITION RELATED TO:					
<ul> <li>Select whether the patient's condition is related to an auto accident and enter the state in which the acciden occurred. Use two-character abbreviation, i.e. OK. S</li> <li>Select whether the patient's condition is related to any other type of accident. S</li> <li>CLAIM CODES (DESIGNATED BY NUCC) C</li> <li>(11 thru 11d, refer to BCBS subscriber coverage)</li> <li>INSURED'S POLICY GROUP OR FECA NUMBER C</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX C</li> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) C</li> <li>Enter the subscriber's employer or school name.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) C</li> <li>Enter the subscriber's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME C</li> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>Select whether there is another health insurance plan, seessary to coordinate benefits with othe insurance companies.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE C</li> <li>Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE C</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER CLAIM ID (DESIGNATED DERSON'S SIGNATURE C</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) C</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) C</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATE SPATIENT UNABLE TO WORK IN CURRENT OCCUPATION S</li> <li>Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S</li> <li>Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required o</li></ul>							
<ul> <li>occurred. Use two-character abbreviation, i.e. OK. S</li> <li>Select whether the patient's condition is related to any other type of accident. S</li> <li>(11 thru 11d, refer to BCBS subscriber coverage)</li> <li>INSURED'S POLICY GROUP OR FECA NUMBER R Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX R Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) R Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) R Enter the subscriber's marker plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>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 othe insurance companies.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE R Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE R Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S Enter the referring, ordering or supervising provider.</li> <li>OTHER ID# R </li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S </li> <li>Enter the referring, ordering or supervising provider.</li> <li>OTHER ID# R </li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S </li> <li>Enter the referring, ordering or supervising provider.</li> </ul>	10a.	Select whether the patient's condition is related to employment.					
<ul> <li>10d. CLAIM CODES (DESIGNATED BY NUCC) Control of the subscriber of the subs</li></ul>	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, i.e. OK.					
<ul> <li>(11 thru 11d, refer to BCBS subscriber coverage)</li> <li>INSURED'S POLICY GROUP OR FECA NUMBER IS Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX IS Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) IS Enter the subscriber's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME IS Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN IS 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 othe insurance companies.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE IS Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE IS Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) IS Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION IS Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>MAME OF REFERRING PROVIDER OR OTHER SOURCE IS Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE IS Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE IS Enter the referring, ordering or supervising provider.</li> <li>OTHER IDH IMABLE TO WORK IN CURRENT OCCUPATION IS Enter the referring, ordering or supervising provider.</li> <li>This field is required only if there is a referring, ordering or supervising provider.</li> </ul>	10c.	Select whether the patient's condition is related to any other type of accident.					
<ol> <li>INSURED'S POLICY GROUP OR FECA NUMBER Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) Enter the subscriber's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE 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.</li> <li>OTHER ID# Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).</li> </ol>	10d.	CLAIM CODES (DESIGNATED BY NUCC) 📧					
<ul> <li>Enter the subscriber's group number from their BCBS ID card.</li> <li>INSURED'S DATE OF BIRTH, SEX E Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCW) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) E Enter the subscriber's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME E Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN E 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 oth insurance companies.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE M Not required in filing BCBS claims.</li> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE M Not required in filing BCBS claims.</li> <li>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) E Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE M 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.</li> <li>OTHER IDH M Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).</li> </ul>							
<ul> <li>Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.</li> <li>OTHER CLAIM ID (DESIGNATED BY NUCC) Enter the subscriber's employer or school name.</li> <li>INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN Enter the subscriber's insurance plan, and yd. This information is necessary to coordinate benefits with other insurance companies.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S 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.</li> <li>OTHER IDH PATIENT INAL PARCE OR OTHER SOURCE PATIENT PARCENT OCCUPATION PATIENT ON PARCENT OCCUPATION PATIENT O</li></ul>	11.						
<ul> <li>11b. OTHER CLAIM ID (DESIGNATED BY NUCC) <sup>[MB]</sup> Enter the subscriber's employer or school name.</li> <li>11c. INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>11d. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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.</li> <li>12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims.</li> <li>13. INSURED OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims.</li> <li>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>15. OTHER DATE Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 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.</li> <li>17. OTHER IDH <sup>[M]</sup> Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).</li> </ul>	11a.	Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the					
<ul> <li>11c. INSURANCE PLAN NAME OR PROGRAM NAME E Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>11d. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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.</li> <li>12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE REMEMBER, if there is another health insurance of the presence of the</li></ul>	11b.	OTHER CLAIM ID (DESIGNATED BY NUCC)					
<ul> <li>Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma</li> <li>11d. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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.</li> <li>12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE 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.</li> <li>13. INSURED OR AUTHORIZED PERSON'S SIGNATURE Remember, if there is a nother health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.</li> <li>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Complete the date using an eight-digit date format (MM/DD/CCYY).</li> <li>15. OTHER DATE Selection and eight-digit date format (MM/DD/CCYY).</li> <li>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Selection and eight-digit date format (MM/DD/CCYY).</li> <li>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Selection the referring, ordering or supervising provider.</li> <li>17. OTHER ID# Men Not required only if there is a referring, ordering or supervising provider.</li> <li>17. OTHER ID# Men Not required for taxonomy code (preceded by "ZZ" qualifier).</li> </ul>		Enter the subscriber's employer or school name.					
<ul> <li>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.</li> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE Research of the provided o</li></ul>							
<ol> <li>PATIENT OR AUTHORIZED PERSON'S SIGNATURE Relation of the provider of the provider</li></ol>	11c.	INSURANCE PLAN NAME OR PROGRAM NAME					
<ol> <li>INSURED OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims.</li> <li>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S 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.</li> <li>OTHER ID# M Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).</li> </ol>	11c. 11d.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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					
<ul> <li>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)          Enter the date using an eight-digit date format (MM/DD/CCYY).     </li> <li>OTHER DATE          Enter the date using an eight-digit date format (MM/DD/CCYY).     </li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION          Enter the date using an eight-digit date format (MM/DD/CCYY).     </li> <li>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION          Enter the date using an eight-digit date format (MM/DD/CCYY).     </li> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE          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.     </li> <li>OTHER ID#          Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).     </li> </ul>	11d.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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 othe insurance companies. PATIENT OR AUTHORIZED PERSON'S SIGNATURE					
<ul> <li>15. OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S Enter the date using an eight-digit date format (MM/DD/CCYY).</li> <li>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE S 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.</li> <li>17a. OTHER ID# M Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).</li> </ul>	11d. 12.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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 othe insurance companies. PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE					
Enter the date using an eight-digit date format (MM/DD/CCYY).  NAME OF REFERRING PROVIDER OR OTHER SOURCE S 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.  Ta. OTHER ID# M Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).	11d. 12. 13.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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 othe insurance companies. PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)					
<ul> <li>NAME OF REFERRING PROVIDER OR OTHER SOURCE S 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.</li> <li>OTHER ID# M Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).</li> </ul>	11d. 12. 13. 14.	INSURANCE PLAN NAME OR PROGRAM NAME R Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma 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. PATIENT OR AUTHORIZED PERSON'S SIGNATURE R Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE R Not required in filing BCBS claims. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) R Enter the date using an eight-digit date format (MM/DD/CCYY). OTHER DATE S					
17a. OTHER ID# M Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).		INSURANCE PLAN NAME OR PROGRAM NAME R Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma 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. PATIENT OR AUTHORIZED PERSON'S SIGNATURE R Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE R Not required in filing BCBS claims. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) R Enter the date using an eight-digit date format (MM/DD/CCYY). OTHER DATE S Enter the date using an eight-digit date format (MM/DD/CCYY). DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S					
	11d. 12. 13. 14. 15. 16.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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. PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Enter the date using an eight-digit date format (MM/DD/CCYY). OTHER DATE Enter the date using an eight-digit date format (MM/DD/CCYY). DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Enter the date using an eight-digit date format (MM/DD/CCYY). NAME OF REFERRING PROVIDER OR OTHER SOURCE Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials.					
	11d. 12. 13. 14. 15. 16. 17.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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. PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Enter the date using an eight-digit date format (MM/DD/CCYY). OTHER DATE Enter the date using an eight-digit date format (MM/DD/CCYY). DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Enter the date using an eight-digit date format (MM/DD/CCYY). NAME OF REFERRING PROVIDER OR OTHER SOURCE 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. OTHER DIF ME					
	11d. 12. 13. 14. 15. 16. 17.	INSURANCE PLAN NAME OR PROGRAM NAME Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Oklahoma IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN 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 othe insurance companies. PATIENT OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. INSURED OR AUTHORIZED PERSON'S SIGNATURE Not required in filing BCBS claims. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) Enter the date using an eight-digit date format (MM/DD/CCYY). OTHER DATE Enter the date using an eight-digit date format (MM/DD/CCYY). DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Enter the date using an eight-digit date format (MM/DD/CCYY). NAME OF REFERRING PROVIDER OR OTHER SOURCE 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. OTHER DH Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).					

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)

 Not required in filing BCBS claims.

### 20. OUTSIDE LAB/CHARGES 📧

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. OK does NOT allow pass through billing.

- DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Enter the ICD-10-CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional ICD-10-CM codes can be entered.
- 22. RESUBMISSION <sup>™</sup> Not required in filing BCBS Claims
- 23. PRIOR AUTHORIZATION NUMBER
- Not required in filing BCBS Claims.

   24.
   SHADED AREA SUPPLEMENTAL INFORMATION -The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia 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).
- **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-10-CM diagnosis code or codes for each procedure performed. Enter one code per line of service.
- 24f. CHARGES R Enter the charge for each line of service. Do not include discounts.

#### 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 Not required, reserved for taxonomy code qualifier, "ZZ."
- 24j. RENDERING PROVIDER ID. # SHADED FIELD R Not required, 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 ID NUMBER R Enter the Federal Tax ID 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" if the provider should be paid, or select "No" if the patient should be paid.
- 28. TOTAL CHARGE R
  - Enter the total charge for all services (total of all charges in 24f).
- 29. AMOUNT PAID S
- Enter any amount paid by the patient only. Do not enter any amount by Medicare or other insurance.
- RSVD FOR NUCC USE NR ME Enter the difference, if any, between the total charge and the amount paid.
- 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS 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).

SERVICE FACILITY LOCATION INFORMATION S
Enter the location where the services were rendered. Required if the service location address is different
than the billing address.

- 32a. NPI S Enter the 10-digit NPI number of the service facility location.
- 32b. OTHER ID# 5
  - Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).
  - BILLING PROVIDER INFO AND PH# R
  - Enter the information of the billing provider or supplier to be paid for services
- 33a. NPI R

33.

- Enter the 10-digit NPI number of the billing provider.
  33b. OTHER ID# S
- Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

# **Place of Service Codes**

For information on Place of Service Codes, see the <u>Centers for Medicare & Medicaid Services Place of</u> <u>Service Code Set</u>.

# Instructions and Examples of Supplemental Information in Item Number 24

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

- Narrative description of unspecified codes
- National Drug Codes for drugs
- Contract rate
- Tooth numbers and areas of the oral cavity

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

ZZ	Narrative description of unspecified code			
N4	National Drug Codes			
CTR	Contract rate			
JP	Universal/National Tooth Designation System			
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity			

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

# Reminders

Complete all required fields. Be sure to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- 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:

- You may reduce your overhead. Electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in BCBSOK's system just the way they leave your office.
- 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.

To obtain more information on electronic claim filing, email BCBSOK <u>Electronic Commerce Services</u> for assistance or visit the <u>BCBSOK Provider website</u>.