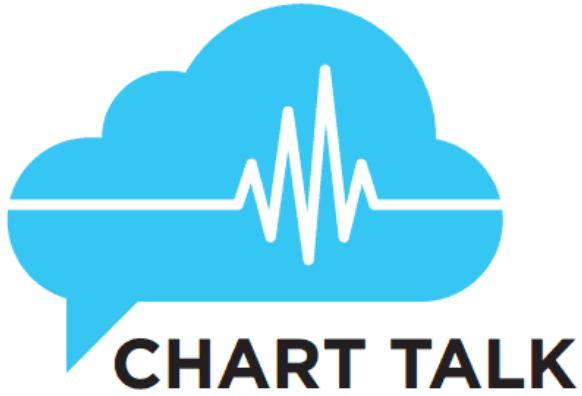
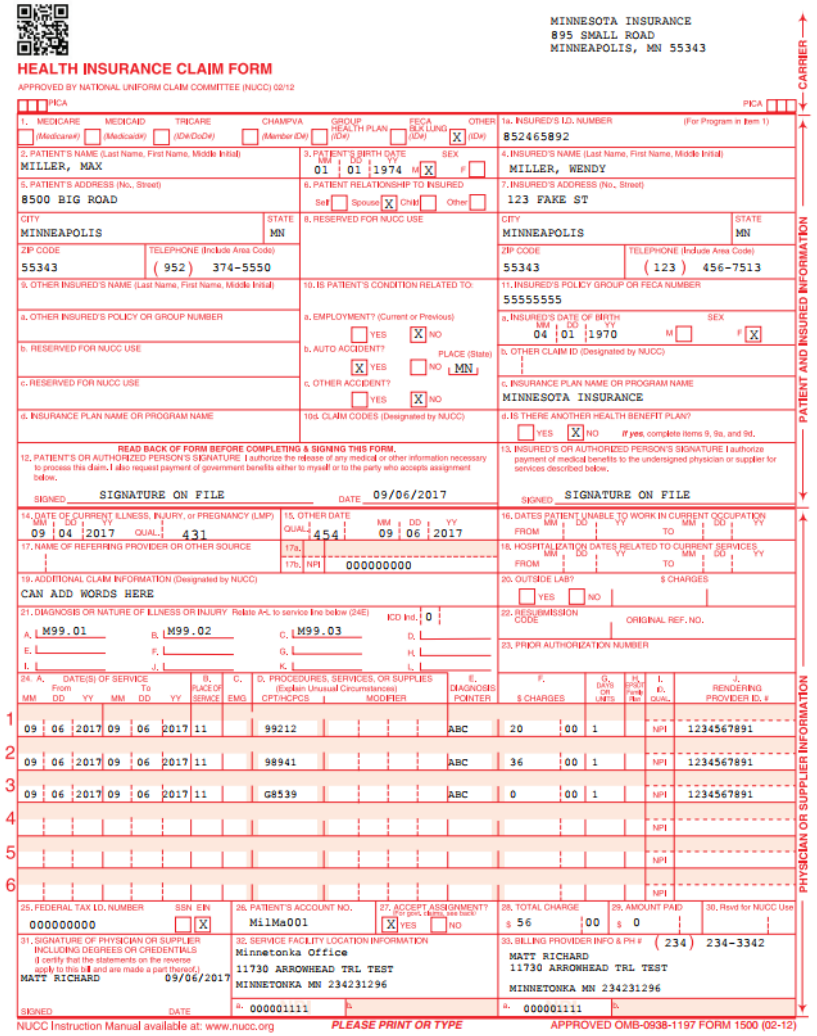


Coach's Corner

Building the CMS 1500 in Chart Talk

Screens used building the 1500

- Payer Configuration
- Patient Payer Configuration
- Location
- Practice Group
- Visit
- User
- Patient Info



MINNESOTA INSURANCE
895 SMALL ROAD
MINNEAPOLIS, MN 55343

HEALTH INSURANCE CLAIM FORM

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

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER						1a. INSURED'S I.D. NUMBER	
						852465892	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE / SEX				4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
MILLER, MAX		01 01 1974 M X F				MILLER, WENDY	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)	
8500 BIG ROAD		Self / Spouse X / Child / Other				123 FAKE ST	
CITY	STATE	8. RESERVED FOR NUCC USE				CITY	STATE
MINNEAPOLIS	MN					MINNEAPOLIS	MN
ZIP CODE	TELEPHONE (Include Area Code)					ZIP CODE	TELEPHONE (Include Area Code)
55343	(952) 374-5550					55343	(123) 456-7513
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER	
						55555555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH / SEX	
		YES / X NO				04 01 1970 M F X	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)	
		X YES / NO MN					
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME	
		YES / X NO				MINNESOTA INSURANCE	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
						YES / X 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 SIGNATURE ON FILE DATE 09/06/2017

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 SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 09 04 2017 QUAL. 431	15. OTHER DATE QUAL. 454 MM DD YY 09 06 2017	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI 000000000	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CAN ADD WORDS HERE		20. OUTSIDE LAB? $ CHARGES YES / NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M99.01 B. M99.02 C. M99.03 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From To MM DD YY 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 09 06 2017 09 06 2017	11		99212		ABC	20 00	1		NPI	1234567891
2 09 06 2017 09 06 2017	11		98941		ABC	36 00	1		NPI	1234567891
3 09 06 2017 09 06 2017	11		G8539		ABC	0 00	1		NPI	1234567891
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
000000000 X	MilMa001	X YES / NO	$ 56 00	$ 0	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
MATT RICHARD 09/06/2017 SIGNED DATE	Minnetonka Office 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296 a. 000001111 b.	MATT RICHARD 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296 (234) 234-3342 a. 000001111 b.

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

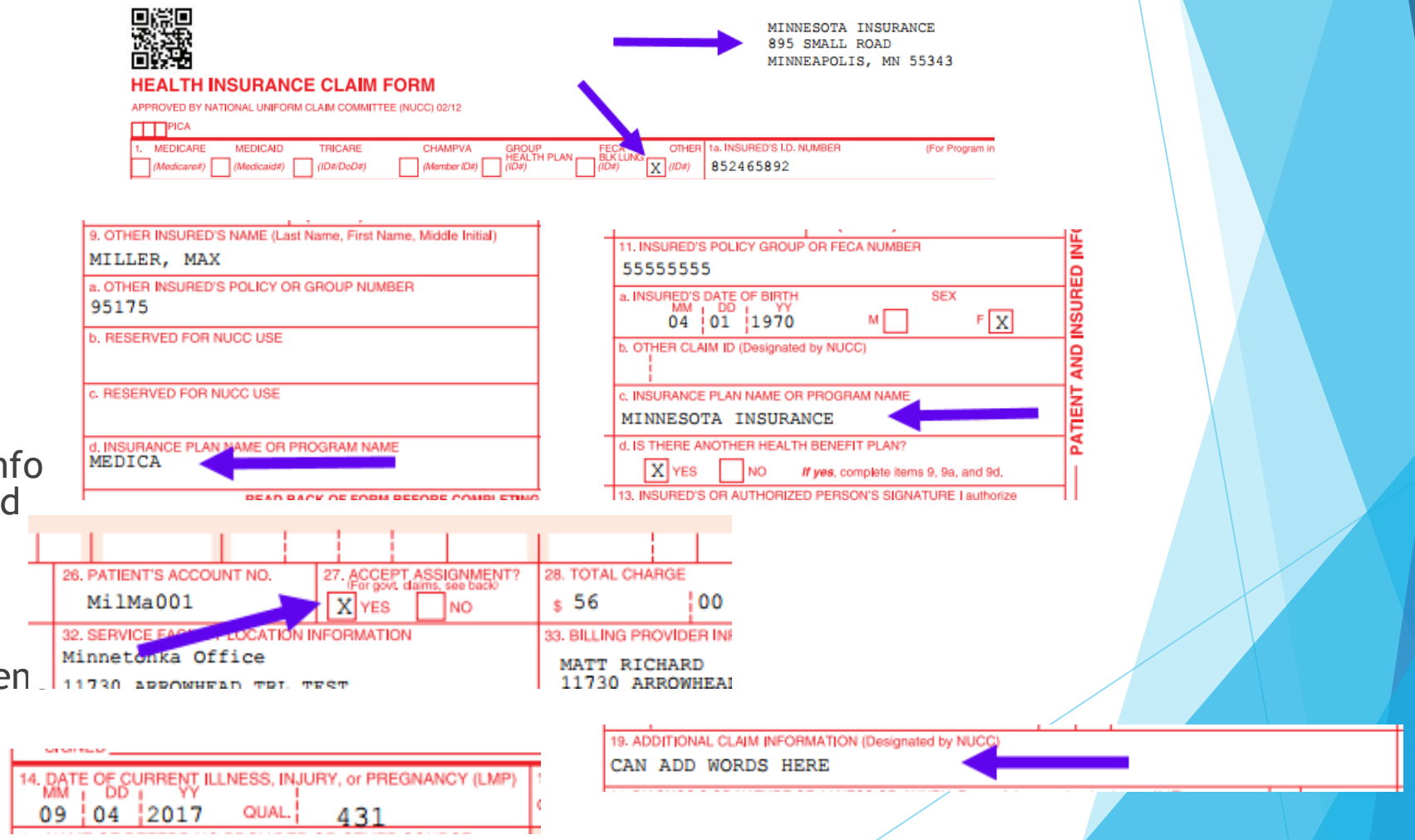
Payer Configuration

Fields Affected

- Top Address
- Box 1
- Box 9d
- Box 11c
- Box 19 – IF 'Standard Text' is TRUE claim info value will be included
- Box 27

LOGIC

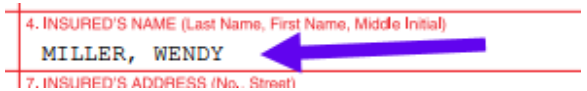
- Box 14 – 'Show Acciden Date' set to TRUE

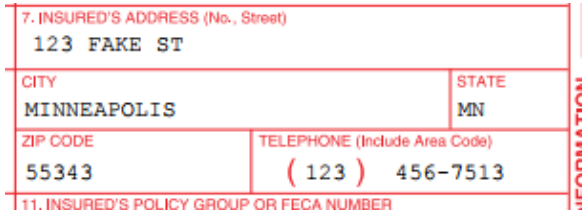


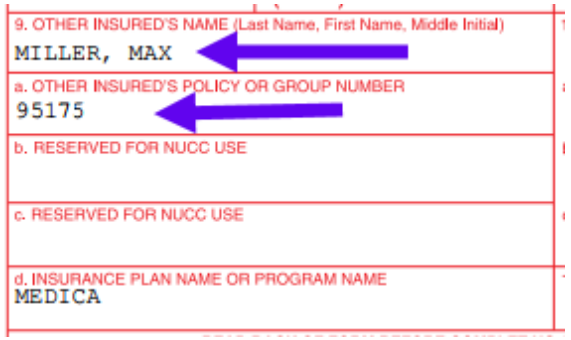
Patient Payer Configuration

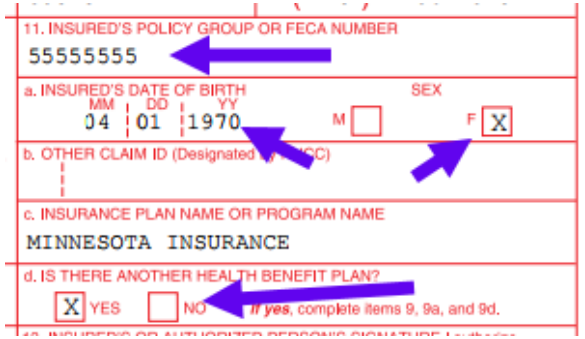
Fields Affected

- Box 1a
- Box 4
- Box 7
- Box 9, 9a – When secondary payer exists
- Box 11, 11a
- Box 27

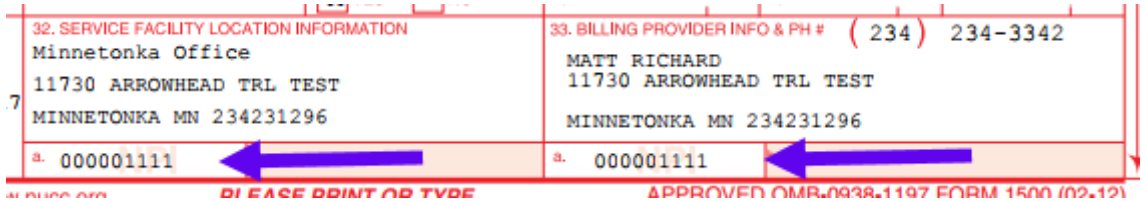








Locations



Fields Affected

- Box 32 – IsBilling MUST be checked
- Box 33 – IsService MUST be checked

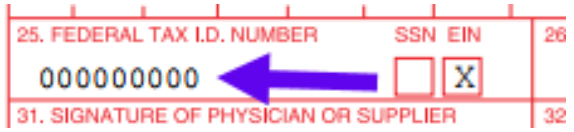
LOGIC

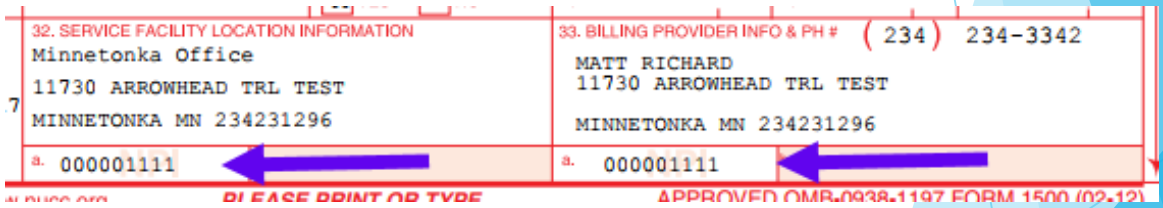
- BOX 32a - IF 'Use This' is selected, this NPI will be used over Group or Provider
- BOX 33a - IF 'Use This' is selected, this NPI will be used over Group or Provider

Group

Logic

- Box 25 – WHEN provider is a member, Group NPI used here
- Box 32a - WHEN provider is a member, Group NPI used here OVER provider NPI
- Box 33a - WHEN provider is a member, Group NPI used here OVER provider NPI





Visit

Fields Affected

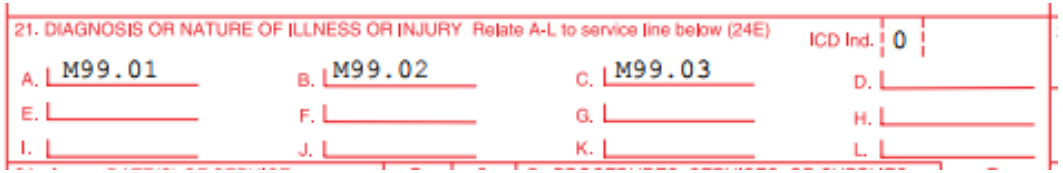
- Box 21
- Box 24
- Box 28
- Box 31

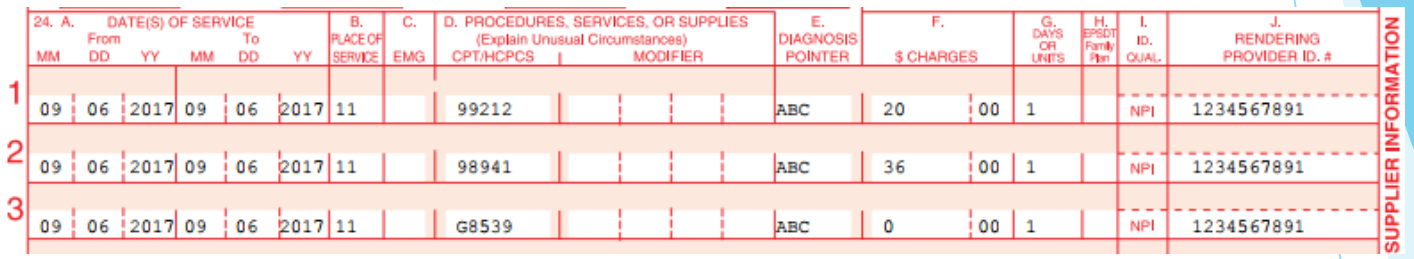
LOGIC

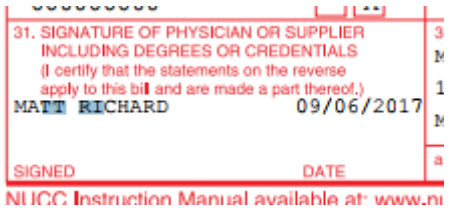
- BOX 10 - IF Visit Type 'isAccident' options for Auto, Work, Other enabled.

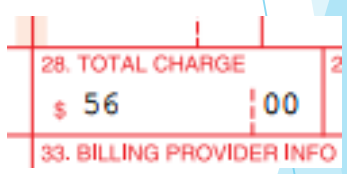
  If Auto selected, State options enabled

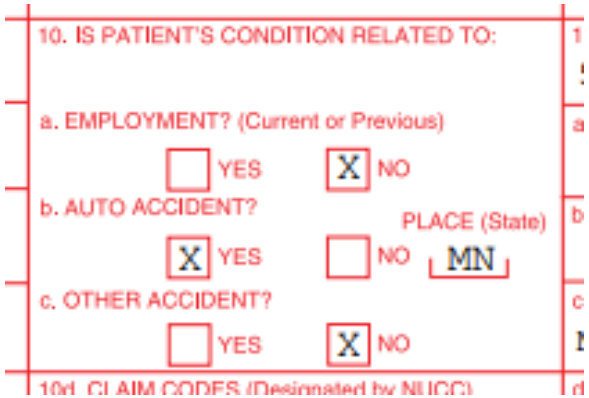
- Box



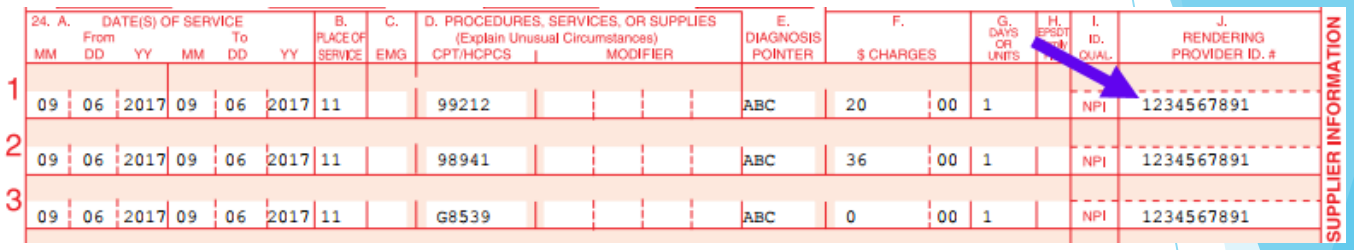








User Profile



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 09	06	2017	09	06	2017	11		99212		ABC	20 00	1		NPI	1234567891
2 09	06	2017	09	06	2017	11		98941		ABC	36 00	1		NPI	1234567891
3 09	06	2017	09	06	2017	11		G8539		ABC	0 00	1		NPI	1234567891

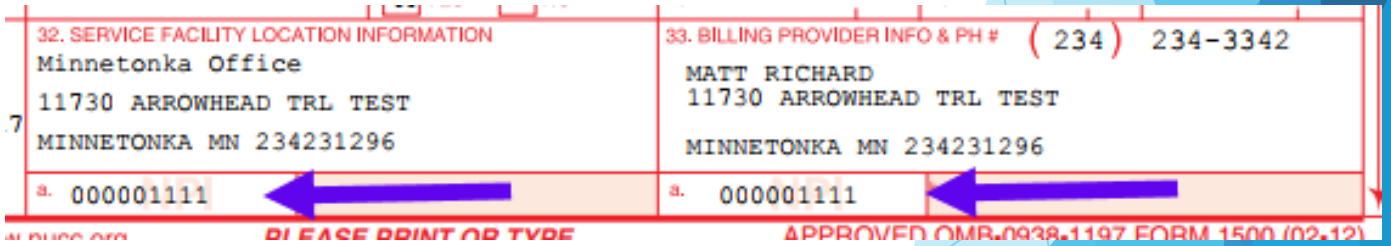
SUPPLIER INFORMATION

Fields Affected

- Box 24j
- Box 31

LOGIC

- BOX 32a -This NPI will be used over WHEN not overridden by Group or Location
- BOX 33a - This NPI will be used over WHEN not overridden by Group or Location



32. SERVICE FACILITY LOCATION INFORMATION
Minnetonka Office
11730 ARROWHEAD TRL TEST
MINNETONKA MN 234231296
a. 000001111

33. BILLING PROVIDER INFO & PH # (234) 234-3342
MATT RICHARD
11730 ARROWHEAD TRL TEST
MINNETONKA MN 234231296
a. 000001111

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Patient Info

Fields Affected

- Box 2
- Box 3
- Box 5
- Box 17 – When referring provider exists AND is selected as main
- Box 26
- Box 29 – Sum of payments from Manage Payment screen