Claim requirements, coordination of benefits and payment disputes

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General guidelines

Tufts Health Plan processes completed, clean claims that meet the conditions of payment and that are submitted within the time frame identified in the provider's contract with Tufts Health Plan. Completed claims are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately. Refer to the Claim Specifications section in this chapter.

Claims must be submitted within the contracted filing deadline according to the date of service, date of discharge, or date of the primary insurance carrier's explanation of payment (EOP). Tufts Health Plan will deny claims submitted after the filing deadline, and the member may not be held responsible for payment. Refer to the Filing Deadline section of this chapter for more information.

Additional guidelines, payment policies, and clinical coverage criteria for specific services are available on the Tufts Health Plan Provider website. To ensure accurate claims processing, providers must follow the payment policies on the Point32Health Provider website.

Electronic data interchange claims

Tufts Health Plan encourages direct electronic submission to the plan. To be accepted, claims submitted directly to Tufts Health Plan must be in HIPAA-compliant standard 837 format and include all required information. Refer to the 837

Companion Guide for additional information. All methods of electronic data interchange (EDI) claim submission produce claim reports that can be accessed electronically. These reports are used to confirm the receipt of claims, as well as to follow up on rejected claims.

When required information is missing, Tufts Health Plan or the clearinghouse will reject the claim. If an electronic claim is rejected, a clean electronic claim must be resubmitted no later than 60 calendar days from the date of service. For additional information, refer to the Avoiding EDI Claim Rejections document.

EDI submission commonly refers to claims transactions, but can be applied to other transaction types as well. Tufts Health Plan offers options for electronic referrals, online eligibility inquiries and claim status information.

For more information about electronic transactions or a setup request., visit the Electronic Services section of the Provider website or contact Tufts Health Plan's EDI Operations Department at EDI_operations@point32health.org.

Paper claims

Some claims cannot be submitted electronically. Claims that must be submitted on industry-standard paper forms include:

- Claims requiring additional supporting documentation, such as operative or medical notes
- Services with a zero-amount billed (except ambulatory surgical claims)
- Unlisted procedure codes that require explanations or descriptions

Paper claim submission requirements

All paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms provided by W.B. Mason. Black and white versions of these forms, including photocopied versions, faxed versions and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning will not be accepted and will be returned with a request to submit on the proper claim form.

To avoid a filing deadline denial, rejected paper claims must be received by Tufts Health Plan within 60 calendar days from the date of service for professional or outpatient services or within 60 calendar days from the date of discharge.

Submitted paper claim forms should include all mandatory fields, as noted in the Claim Specifications section of this chapter. Paper claim forms deemed incomplete will be rejected and returned to the submitter. The rejected claim will be returned to the submitter along with a letter stating the reason for the rejection, and a new claim with the required information must be resubmitted for processing.

- Industry-standard codes should be submitted on all paper claims.
- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form.
- Remove all staples from claims and supporting documentation.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include, but are not limited to, the following:
  - Illegible claim forms
  - Member ID number
  - Date of service or admission date
  - Physician's signature (CMS-1500 Box 31)
  - Place of service

Paper claims should be mailed to:
Tufts Medicare Preferred or Tufts Health Plan SCO, P.O. Box 518, Canton, MA 02021-0518

Claims payment

Clean claims

Medicare defines a clean claim as a claim that does not require the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the filing period. For information about the forms to use for submitting claims, refer to the Claim Specifications section in this chapter.

To qualify for payment, clean claims must also meet the following conditions of payment:

- The billed services must be:
  - Covered in accordance with the applicable benefit document provided to members who meet eligibility criteria and who are members on the date of service
  - Furnished by a provider eligible for payment under Medicare and/or Medicaid, as applicable
  - Provided or authorized by the member's PCP or the PCP's covering provider in accordance with the applicable benefit document, or as identified elsewhere in the provider's contract with Tufts Health Plan (if applicable)
  - Covered pursuant to the member's evidence of coverage documents
  - Medically necessary as defined in the Medicare and/or Medicaid coverage guidelines, as applicable
- Tufts Health Plan received the claim within 60 calendar days of the date of service (or date of discharge if the member was inpatient), or date of the primary insurance carrier's EOP.
- The services were preregistered and/or prior authorized in accordance with Tufts Health Plan's inpatient notification procedures.
- The services were billed using the appropriate procedure codes
- In the case of professional services billed by the hospital, services were billed electronically according to the HIPAA standard or on CMS-1500 and/or UB-04 forms with a valid CPT code and/or HCPCS code.
- "Clean claims" do not include a claim from a provider who is under investigation for fraud or abuse.

All services rendered to Tufts Medicare Preferred and/or Tufts Health Plan SCO members must be reported to Tufts Health Plan as encounter or claims data. An encounter is a billing form submitted by capitated providers for tracking purposes. Claim forms are submitted by non-capitated providers for both payment and tracking purposes.

Explanation of payment (EOP)

The Tufts Health Plan explanation of payment (EOP) is a weekly report of all claims that have been paid, pended, or denied to that provider. The EOP will also include a summary of claims in process. This summary indicates the claims that Tufts Health Plan has received, however, may require additional review or information before being finalized in the system. The EOP for capitated providers shows zero dollars paid, and the pay code indicates that services were prepaid under the capitation agreement. The EOP for non-capitated providers indicates the amount paid, denied or pended, with a message code indicating the claim status.

EOPs may be viewed electronically by logging on to the PaySpan Health website and electronic versions of EOPs are available for download and printing on the PaySpan Health website.

Summary of claims in process

Tufts Health Plan generates a weekly Summary of Claims in Process report that shows all claims received to date and pending for payment. The Summary of Claims in Process reports is similar to the EOP report, except "Summary of Claims in Process" appears at the top of the barred section and pay codes display a pending message, rather than a payment or denial message. Once adjudicated, all entries on the Summary of Claims in Process report appear on the EOP.

Electronic remittance advice (ERA)

Tufts Health Plan now offers the 835 Health Care Claim Payment Advice through PaySpan Health. This electronic remittance advice (ERA) includes paid and denied claims submitted either via EDI or on paper forms and uses HIPAA-standard reason codes.

All registration and support questions for retrieving an 835 from PaySpan Health and for ongoing support is handled by PaySpan Health Provider Support Team via their website or phone by dialing 877-331-7154, option 1. Provider Support Team specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m., EST.

Claims reports

Tufts Health Plan sends the following reports to medical groups regarding claims for members in their group:

- The biweekly **adjusted claims report** includes claims that Tufts Health Plan has retracted and reprocessed. Medical groups can then review claims that have been adjusted for denial or payment.
- Two **paid claims reports** are generated biweekly and show claims processed from the Medical Services Fund and those processed from the Hospital Services Fund. These reports allow the medical group to review claims processed from each service fund.

Retroactive denials (Tufts Health Plan SCO)

Effective for behavioral health claims received on or after July 1, 2019, Tufts Health Plan may reprocess claims in accordance with our adjudication guidelines to ensure appropriate payment for services rendered. In accordance with state law governing Massachusetts Medicaid plans, Tufts Health Plan sends notification to behavioral health providers in Massachusetts and allows 30 calendar days for a response prior to retroactively denying or adjusting claims to reduce payment for behavioral health services. If communication is not received from the provider within 30 calendar days (15 calendar days for coordination of benefits or worker's compensation claims), the claim will be readjusted and processed.

Corrected claims, adjustments, disputes and appeals

Tufts Health Plan accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), Medicare Managed Care Manual and HIPAA EDI standards for Tufts Health Plan claims.

Online adjustment requests

Registered providers may submit corrected claims or dispute a claim using Tufts Health Plan's secure provider portal. Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation the adjustment has been received. Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating the claim is not adjustable. In this instance, claim adjustments may be submitted on paper.

Provider Services is unable to process claim adjustment requests.

EDI submissions

To submit a corrected facility or professional claim via EDI:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in **Loop 2300, CLM05-3** as one of the following:
  - **7** (corrected claim)
  - **5** (late charges)
  - **8** (void or cancel a prior claim)
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter **REF*F8*23456789**.

Note: Provider payment disputes that require additional documentation **must** be submitted on paper.

Paper submissions

Tufts Health Plan requires the Request for Claim Review Form for provider payment disputes submitted by mail (mailing address is noted on the form).

Forms must be submitted with all required information, as denoted by asterisks (*). Incomplete forms will be returned to the submitting provider for completion and resubmission.

- If the original claim was denied, enter the Tufts Health Plan denial code in the 'Denial Code' field (do not use HIPPA message codes)
- Supporting documentation must be single-sided
- Disputes submitted without the Request for Claim Review Form will be rejected and returned to the submitter.
- Please provide one claim number, per form. Multiple claim numbers on one form are not accepted. To expedite the review process, when submitting hospital records, please include the page numbers for the history, physical and discharge summaries and also submit on single sided pages.

  Note: Payment disputes cannot be submitted via EDI; however, corrected claims may be submitted via EDI using the appropriate frequency code. Follow the instructions when submitting online claim adjustments

Facility claims

On the UB-04 (CMS-1450) form, enter either **7** (corrected claim), **5** (late charges), or **8** (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill), and enter the original claim number in Box 64 (Document Control Number). This information should match the Review Type section of the Request for Claim Review Form, which is a required form.

Professional claims

In Box 22 on the CMS-1500 form, enter the frequency code **7** under "Code" and the original claim number in the same box under "Original Ref No." Please include the required Request for Claim Review Form.

Filing deadline

The standard filing deadlines are as follows:

- 60 days from the date of service for professional (CMS-1500) claims
- 60 days from the claim end date when interim billing is allowed, for example for certain inpatient stays at a rehabilitation facility, long term acute care hospital or skilled nursing facility, and certain outpatient services with hospice or home health care agency
- 60 days from date of hospital discharge when interim billing is not allowed

The timely filing window begins on the date entered in the 'to' date in Box 24A for professional (CMS-1500) claims or in the 'through' date in Box 6 for institutional (UB-04) claims.

Tufts Health Plan will deny claims submitted after the filing deadline for failure to meet timely filing requirements. Members may not be billed for services that have been denied for exceeding the filing deadline. If a member has multiple insurance plans, the filing deadline for claims submission is 60 calendar days from the date of the primary insurer's EOP.

Filing deadline adjustments

Requests to review and adjust claims that were denied for timely filing must be submitted within 120 calendar days of the EOP date on which the claim originally denied. Disputes received after 120 calendar days will not be considered.

Proof of timely filing

Documented proof of timely submission must be submitted with any request for review and payment of a claim that was previously denied due to the filing deadline.

The following are considered acceptable proof of timely submission for paper claims submissions: Please include the required Request for Claim Review Form for each claim number.

- Copy of EOB/EOP from the primary insurer that shows timely submission from the date that carrier processed the claim
- Printout of patient account ledger that shows the date that the member was billed, when insurance information is not made available by the member
- Copy of EOP from another carrier if the member did not identify him/herself as a Tufts Health Plan member at the time of service
- Copy of a personal injury protection (PIP) letter received by Tufts Health Plan within 90 calendar days of the date on the letter
- Copy of a workers' compensation denial received by Tufts Health Plan within 90 calendar days of the date of the denial

The following are considered acceptable proof of timely submission for electronic claims submissions:

- Providers who submit their claims electronically through a clearinghouse, MD On-Line or directly to Tufts Health Plan must send:
  - A copy of the report that shows the claim was accepted at Tufts Health Plan with a claim number
  - The corresponding EDI vendor or clearinghouse claim acknowledgement report or HIPAA 277CA showing that the claim was received by Tufts Health Plan, as evidenced by a Tufts Health Plan claim number.

If a report indicates a rejection at the clearinghouse, the claim will not be considered for reprocessing. It is the provider's responsibility to review all reports from the clearinghouse and/or Tufts Health Plan and review any rejected claims at that time. Rejected claims must be corrected and received by Tufts Health Plan within the previously stated timely filing limits.

Circle the claim that is disputed on both the report(s) and the EOP. Details on the report requirements are listed below:

EDI Through	Reports Required for Proof of Timely Submission	Report Detail
Direct to Tufts Health Plan One or the other required	Claims Acceptance Summary Report **or** Claims Acceptance Detail Report	Claims accepted at Tufts Health Plan by claim number
Change Healthcare™/ WebMD/Envoy One or the other required	Provider Claim Status Report (RPT-10) **or** Special Handling/Unprocessed Claims Report (RPT-11)	Claims accepted at Tufts Health Plan by claim number
Change Healthcare™/ WebMD/Healthwire One or the other required	Provider Claim Status Report (RPT-10) **or** Special Handling/Unprocessed Claims Report (RPT-11)	Claims accepted at Tufts Health Plan by claim number
Capario	INS (insurance) Response Report	Claims accepted at Tufts Health Plan by claim number
MD On-line	Acceptance Report in your **LinkMail Box**	Claims accepted at Tufts Health Plan by claim number

If acceptable proof of timely submission is received, the claim will be reprocessed. When the disputed claim is reprocessed, a subsequent denial may be generated. In this instance, a new dispute must be submitted with the appropriate proof since each denial is based on the current message code on the claim. Please include the required Request for Claim Review Form.

If the initial claim submission is after the filing deadline and the circumstances for the late submission are beyond the provider's control, the provider may submit a payment dispute for reconsideration by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing deadline and any supporting documentation.

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- Verbal requests

Requests for filing deadline adjustments should be sent to the following address with the required Request for Claim Review Form for each claim number:
Tufts Medicare Preferred or Tufts Health Plan SCO, P.O. Box 478, Canton, MA 02021-0478

Provider disputes and appeals

Providers who disagree with the compensation, adjudication or denial of a claim can submit a payment dispute. Payment disputes must include a copy of the EOP, appropriate documentation and a completed Request for Claim Review Form. The mailing address is Tufts Medicare Preferred or Tufts Health Plan SCO, P.O. Box 478, Canton, MA 02021-0478. Registered providers may submit disputes and appeals using the secure provider portal. Providers who are not registered users of the website may register via the Provider login page

Compensation/reimbursement appeals

- Submit a typed letter of medical necessity (LOMN) explaining why the service was necessary.
- Attach the EOP and circle the claim to be reviewed
- Submit all supporting documentation in the form of invoices, operative notes, office notes, radiology/pathology report(s) or any necessary medical record information for a fee adjustment request.

Appeals for unlisted procedure code denials

Appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code.

Note: The portion of the operative notes that identifies the unlisted service must be underlined. Operative notes that are not underlined to indicate the service performed may delay consideration of payment.

Appeals for lack of information, prior authorization, inpatient notification, or level of care

- Email the Request for Claim Review Form to SP_Provider_Appeals@point32health.org to appeal claims for lack of prior authorization/notification and compensation/reimbursement. All other disputes, providers should continue to mail to the appropriate address listed on the Request for Claim Review Form.
- Include the rationale for disputing the denial along with the necessary supporting clinical documentation.
- Attach a copy of the claim and the EOP.
- Lack of prior authorization denials may only be appealed with evidence the proper procedure was followed, or with a valid reason the proper procedure to obtain the appropriate authorization was not followed.
- Lack of Information denials should include the pertinent clinical information as well as an explanation of the reason clinical information was not communicated concurrently, or evidence that the information was transmitted.
- Level of care appeals should include clinical information to justify an inpatient level of care, including Interqual acute criteria and records supporting the contention that these criteria were met concurrently, or a justification for an exception to those criteria.

Relevant supporting documentation includes a copy of the provider's original information faxed/submitted to Tufts Health Plan and relevant medical records. If authorization is applicable, please include the authorization number received verbally or in writing from Tufts Health Plan.

Limitation of dispute process

Tufts Medicare Preferred HMO and Tufts Health Plan SCO will consider payment disputes and adjustment requests for claims with dates of service within the current year and the two previous calendar years. Corrected claims and duplicate claim denial disputes received after that time will not be considered.

Note: Cloned documentation (i.e., information that is duplicated across patient documentation that is not specific to the encounter and/or member) does not meet medical necessity requirements and will not be accepted as evidence of the service billed.

Returned funds

Providers must complete and submit a Returned Funds Form and payment EOP for claims requesting to be refunded to the Finance Services Team when returning funds to Tufts Health Plan due to incorrect payments. Submitting funds without the form and supporting documentation can delay the process of having the funds allocated back to the provider's account.

Coordination of benefits (COB)

Regardless of whether Tufts Health Plan is the primary or secondary insurer, members must follow plan procedures to receive benefits. For additional information, refer to the Coordination of Benefits Policy.

Motor vehicle accidents (MVA)

Tufts Health Plan coordinates with auto insurance coverage, including personal injury protection (PIP) and/or Medical Payment (MedPay) on claims for services rendered as a result of an MVA.

The auto insurance coverage is primary for the full PIP coverage and/or any available MedPay coverage until all benefits are exhausted. Providers should bill the motor vehicle carrier directly. Members should not be billed or required to pay up front for services as a result of an MVA, other than applicable cost-sharing amounts.

If further payment is requested after receiving the insurer's statement or check, providers must submit a copy of the auto carrier's documents (i.e., PIP exhaust or benefit denial letter) along with the claim(s) to Tufts Health Plan within the 60-calendar day filing deadline date from the date the statement or check was issued.

Tufts Health Plan does not accept PIP notification or claim forms from any entities other than the member's motor vehicle insurer and contracting providers of Tufts Medicare Preferred HMO and Tufts Health Plan SCO.

Under the provider's Tufts Health Plan contract, after the member's PIP and MedPay benefits are exhausted, the member cannot be balance-billed or have a lien filed against their third-party settlement or judgment. Do not bill the member or the member's attorney directly, even if requested by either of them. If a provider chooses to bill the member or attorney directly, it is done so at the provider's own risk.

The following applies to claims for services rendered as a result of a motor vehicle accident:

- Claims should be submitted to the motor vehicle insurer first to expedite adjudication
- Claims should not be submitted beyond the filing deadline from the date on the auto insurer's notification of benefit payment, denial, or exhaustion
- Claims should be submitted with dated notification from the auto insurer that benefits have been paid, denied or exhausted
- Inpatient notification procedures for any inpatient admissions resulting from an MVA, regardless of whether or not Tufts Health Plan is the primary or secondary insurer. Refer to the Referrals, Prior Authorizations and Notifications chapter for additional information.

Tufts Health Plan does not routinely compensate conditional bills.

Subrogation

Subrogation is a liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or their insurer).

Tufts Health Plan has outsourced subrogation recovery services to the Rawlings Company in Louisville, Kentucky. Providers may receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries relating to correspondence received by the provider must be directed to the Rawlings Company. All other subrogation questions should be directed to Provider Services at 800-279-9022.

Claim specifications

Completing the UB-04 form

Use the UB-04 form to complete a Medicare claim for institutional services. To complete this form, refer to the UB-04 Claim Form Specifications section below. Field information is required unless otherwise noted. This form may be prepared according to Medicare guidelines as long as all required fields are completed.

Completing the CMS-1500 (02/12) form

Use the CMS-1500 form to submit a Medicare claim for noninstitutional services. All providers, including internal medicine, gynecology and psychiatry, should use ICD-CM diagnosis codes and HCPCS/CPT procedure codes. Oral surgeons may use CDT-3 codes, and dentists may use the ADA procedure codes and ADA form. To complete this form, refer to the CMS-1500 Claim Form Specifications section below.

Unlisted or miscellaneous codes require notes and/or a description of services rendered to be submitted with the claim. Using unlisted or miscellaneous codes will delay claims adjudication and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial and the member may not be held liable for payment.

UB-04 claim form specifications

In the **Type** column below**:** Mandatory fields are marked with M. Optional fields are marked with an O

Box	Field Name	Type	Description
1	Untitled	M	Name and address of the hospital/provider
2	Untitled	M	Address of payee (if different from the address in box 1)
3a-b	Patient control number	O	3a: Patient account number 3b: Medical record number
4	Type of bill	M	3-digit code to indicate the type of bill. Claim will be returned if the type of bill is missing
5	Federal tax number	M	Hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.
6	Statement covers period	M	Beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the “from” and “through” dates will be the same If the “from” and “through” dates differ, then these services must be itemized by date of service (see Box #45)
7	Untitled	N/A	
8a	Patient ID and name	M	8a: Member ID number 8b: Member’s last name, first name and middle initial, if any, as shown on the member’s ID card.
9a-e	Patient address	M	Member’s mailing address from the patient record
10	Birth date	M	Member’s date of birth (MMDDYYYY)
11	Sex	M	Indicate (M)ale or (F)emale
12	Admission date	M	Date of admission/visit **Note:** This field is optional for outpatient services (except home health).
13	Admission hour	M	Time (hour: 00–23) of admission/visit **Note:** This field is optional for outpatient services.
14	Admission type	M	Code indicating the type of admission/visit **Note:** This field is optional for outpatient services.
15	Source of admission (SRC)	M	Code indicating the source of admission/visit

Box	Field Name	Type	Description
16	Discharge hour	M	Time (hour: 00–23) the member was discharged **Note:** This field is optional for outpatient services
17	STAT (Patient discharge status)	M	Indicates the status of the member as of the through date on bill. (The member's status cannot be 'member.')
18-28	Condition codes	O	Code used to identify conditions relating to this bill (can affect payer processing)
29	Accident state	M	Enter the state in which accident occurred
30	Untitled	N/A	
31-34	Occurrence codes and dates	M (if applicable)	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. **Note:** Tufts Health Plan requires all accident-related occurrence codes to be reported.
35-36	Occurrence span code and dates	O	Code and related dates that identify an event that relates to the payment of the claim
37	Untitled	N/A	
38	Untitled	N/A	
39-41	Value codes and amounts	N/A	
42	Revenue code	M	Most current industry standard revenue codes
43	Revenue description	M	Narrative description of services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible
44	HCPCS/rates	M	-Use CPT/HCPCS Level II codes for outpatient procedures, services, and supplies -Do not use unlisted codes. If an unlisted code is used, supporting documentation must accompany the claim -Do not indicate rates
45	Service date	O	Enter all of the dates of service with each date of service reported separately using MMDDCCYY. Please note that this is required for all outpatient claims
46	Units of service	M	Units of service rendered per procedure
47	Total charges	M	Enter the charge amount for each reported line item. A negative amount will not be accepted.
48	Noncovered charges	O	Enter any noncovered charges for the primary payer pertaining to the revenue code.
49	Untitled	N/A	
50 A-C	Payer	M	All other health insurance carriers on file (attach EOB from other carrier, if applicable)
51	Health plan ID	O	Provider number assigned by health insurance carrier
52	Rel. info (release of information)	N/A	
53	Asg ben (assignment of benefits)	N/A	

Box	Field Name	Type	Description
54	Prior payments (payer and patient)	M	Report all prior payment for claim (attach EOB from other carrier, if applicable) A negative amount will not be accepted
55	Est. amount due	N/A	
56	NPI	M	Valid NPI number of the servicing provider
57a-c	Other Prv ID (other provider ID)	N/A	
58a-c	Insured's name	M	Name of the individual who is carrying the insurance
59	P. rel (patient's relationship to insured)	M	Code indicating the relationship of the member to the identified insured/subscriber
60a-c	Insured's unique ID (health insurance claim/identification #)	M	Member's ID number, as shown on the Tufts Health Plan ID card
61a-c	Group name	M	Name of the group or plan through which the insurance is proved to the insured
62a-c	Insurance group number	M	Identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered
63a-c	Treatment authorization code	O	Tufts Health Plan referral/authorization number for outpatient surgical day care services
64a-c	Document control number	N/A	
65a-c	Employer name	M (if applicable)	Name of the employer for the individual identified in box 58
66	DX version qualifier	N/A	
67a-q	Principal diagnosis code	M	ICD-CM code describing the principal diagnosis chiefly responsible for causing admission/visit. The code must be to the appropriate digit specification, if applicable. If the diagnosis is accident related, then an occurrence code and accident date are required. Present on admission (POA) indicator should be entered as the 8th character
68	Other diagnosis codes	M (if applicable)	ICD-CM codes corresponding to additional conditions that coexist at the time of admission or develop subsequently. The code must be to the appropriate digit specification, if applicable.
69	Admit DX	M	ICD-CM code provided at the time of admission as stated by the provider
70	Patient reason DX	O	
71	PPS code (Prospective Payment System)	O	
72	ECI (external cause of injury code)	M (if applicable)	ICD-CM code for the external cause of an injury, poisoning or adverse effect
73	Untitled	N/A	

Box	Field Name	Type	Description
74a-e	Principal procedure code (code and date)	M	Most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for this service billed. Also, enter the date the procedure was performed. Date must be recorded as month and day (MMDD)
75	Unlisted	N/A	
76	Attending physician	M	Ordering physicians NPI, physician's last name, first name and middle initial
77	Operating physician	M (if applicable)	Name and NPI number of the physician who performed the principal procedure
78-79	Other provider types	O	Optional
80	Remarks	O	Examples: "COB-related" or "billing for denial purposes only"
81a-d	ICC	O	Optional

CMS-1500 Form Specifications

In the **Type** column below**:** Mandatory fields are marked with M. Optional fields are marked with an O.

Box	Field Name	Type	Instructions
1	Type of insurance coverage	O	Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional. If the Other box is checked, complete Box #9.
1a	Insured's ID number	M	Enter the member's current identification number exactly as it appears on the member's Tufts Medicare Preferred HMO ID card, including the alpha prefix and number suffix. Inaccurate or incomplete ID numbers will delay processing the claim and can result in a denial.
2	Patient's name	M	Member's last name, first name and middle initial, if any, as shown on the member's ID card.
3	Patient's birth date and sex	M	Member's date of birth and sex.
4	Insured's name	M	If the insured and the member are the same person, enter SAME. If the insured and the member are not the same person, enter the name of the insured (last name, first name and middle initial).
5	Patient's address	M	member's permanent mailing address and telephone number: 2nd line: street address, city and state 3rd line: zip code and telephone number
6	Patient relationship to insured	M	Member's relationship to the insured (i.e., self)
7	Insured's address	M	If the insured's address is the same as member's address, enter SAME. If the insured's address is different than the member's address, enter insured's permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.
8	Reserved for NUCC use	O	

Box	Field Name	Type	Instructions
9	Other insured's name	M	If the insured is the same as the person in Box #4, enter SAME. If the insured is not the same as the person in Box #4, enter name of the other insured (last name, first name and middle initial).
9a	Other insured's policy or group number	M	If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Reserved for NUCC use	O	
9c	Reserved for NUCC use	O	
9d	Insurance plan name or program name	M	Other insured's insurance plan name or program name and attach the other insurer's EOB to the claim.
10a-c	Is patient's condition related to:	M	For each category (Employment, Auto Accident, Other Accident), check either YES or NO. When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection (PIP) benefits have been exhausted. State postal code where the auto accident occurred
10d	Claim codes	O	Up to 4 claim condition codes may be entered
11	Insured's policy group or FECA number	M	If the insured has other insurance, indicate the insured's policy or group number.
11a	Insured's date of birth and sex	M	Insured's date of birth and sex if different from the information in Box #3.
11b	Other claim ID	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter claim number from other insured's plan to the right of the dotted line
11c	Insurance plan name or program name	M	Insurance plan or program name, if applicable (this field is used to determine if supplemental or other insurance is involved)
11d	Is there another health benefit plan?	M	Check YES or NO to indicate if there is another primary health benefit plan. For example, a member may be covered under insurance held by a spouse, parent, or other person
12	Patient's or authorized person's signature	M	If the signature is not on file, the member or authorized representative must sign and date this box If the signature is on file, enter Signature on File If an authorized representative signs, indicate this person's relationship to the member
13	Insured's or authorized person's signature	M	If the signature is not on file, the insured or authorized representative must sign this block to authorize payment of benefits to the participating practitioner or supplier If the signature is on file, enter Signature on File
14	Date of current illness, injury or pregnancy (LMP)	O	Date of current illness, injury or pregnancy in the designated MMDDYY space Qualifier found in the 837 electronic claim to the right of the QUAL dotted line
15	Other date	O	Qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL Date in the designated MMDDYY space

Box	Field Name	Type	Instructions
16	Dates patient unable to work in current occupation	O	Enter dates if the member is unable to work in current occupation. An entry in this box could indicate employment-related insurance coverage
17	Name of referring provider or other source	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line Enter the name of the referring and/or ordering practitioner or other source if the member: -Was referred to the performing practitioner for consultation or treatment -Was referred to an entity, such as clinical laboratory, for a service -Obtained a practitioner's order for an item or service from an entity, such as a DME supplier
17a-b	ID number of referring physician	O	NPI-assigned practitioner ID number of the referring or ordering practitioner Referring practitioner information is required if another practitioner referred the member to the performing practitioner for consultation or treatment Ordering practitioner information is required if a physician ordered the diagnostic services, test or equipment
18	Hospitalization dates related to current services	M	Admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization
19	Additional claim information (designated by NUCC)	O	Additional claim information
20	Outside lab	O	Check YES or NO to indicate if laboratory work was performed outside the practitioner's office
21	Diagnoses	M	Up to 12 ICD-CM 12 codes in priority order (primary, secondary condition) may be entered. Codes are arrayed across the box.
22	Resubmission code	O	Identifies a resubmission code
23	Prior authorization/referral number	O	If applicable, enter the inpatient notification or prior authorization number
24a	Date(s) of service	M	Dates for each procedure in MMDDYY format, omitting any punctuation Itemize each date of service. Do not use a date range
24b	Place of service	M	Appropriate place of service code
24c	EMG	N/A	Check this item if the service was rendered in a hospital or emergency room
24d	Procedures, services, or supplies	M	Valid CPT/HCPCS procedure codes and any modifiers
24e	Diagnosis pointer	M	Diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. Maximum of 4 letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	$ Charges	M	Charges for each listed service
24g	Days or units	M	Days or units of service rendered for the procedures reported in Box 24d
24h	EPSDT family plan	O	Check only if EPSDT or family planning services were used

Box	Field Name	Type	Instructions
24i	ID QUAL	O	Check only if the service was rendered in a hospital emergency room **Note:** If this box is checked, the place of service code in Field #24b should match.
24j	Rendering provider ID #	M	rendering practitioner's NPI number (if different from billing practitioner)
25	Federal Tax ID number	M	Practitioner/supplier's federal tax ID, employer ID number, or Social Security number
26	Patient's account number	O	Member's account number assigned by the physician's/supplier's accounting system **Note:** This is an optional field to enhance member identification by the practitioner or supplier.
27	Accept assignment?	M	Indicate if the practitioner accepts assignment for the claim (by checking yes, the practitioner agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter)
28	Total charge	M	Total charges for the services (total of all charges in Box 24f).
29	Amount paid	M	Total amount paid by any other carrier/entity for the submitted charges in Box 28 Attach supporting documentation of any payments (e.g., EOB, EOP or a copy of a cancelled check, if applicable)
30	Reserved for NUCC use	O	
31	Signature of physician or supplier including degrees or credentials	M	If the signature is not on file, have the physician/supplier or authorized representative sign and date this block. If the signature is on file, enter Signature on File.
32, 32a-b	Service facility location information	M	If other than home or office, enter the name and address of the facility where services were rendered to the member, enter NPI number for the facility (or other ID number, if applicable)
33, 33a	Billing provider info and phone	M	33: Name and payment address of the entity receiving payment (this must match the Tax ID and name on file with the IRS) 33a: NPI number for the entity receiving payment

PUBLICATION HISTORY

03/01/24	updated box 45 in the UB-04 Claim Form section to optional; administrative edits
08/22/24	administrative edit–phone number updated
09/03/24	updated the Description column for Boxes 12, 13, 14, and 16 in the UB-04 Claim Form Specifications table to include notes on outpatient services.
11/14/24	updated links; administrative edits
02/01/25	updated the following sections with content from the archived Provider Payment Dispute Policy: "Corrected Claims, Adjustments, Disputes and Appeals" and "Provider Disputes and Appeals"; administrative edits
04/02/25	updated "Claims Reports" section; administrative edits
01/01/26	removed "Late charges" section in the "Corrected Claims, Adjustments, Disputes and Appeals" section; updated the description for Box 17 in the UB-04 Claim Form Specifications table regarding interim billing; administrative edits
05/06/26	Corrected typo on pg. 5.
11/01/26	updated Filing Deadline for Initial Claims section to add specificity by claim type
11/15/26	updated links to online resources; administrative updates