

Claim Requirements, Coordination of Benefits and Dispute Guidelines

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General Guidelines

Tufts Health Public Plans processes completed, clean claims that meet the conditions of payment and that are submitted within the time frame identified in provider agreements with Tufts Health Public Plans. Completed claims are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately, refer to the [Claims Specifications](#) for further information.

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 benefits (EOB). Tufts Health Public Plans will deny claims submitted after the filing deadline, and the member is not responsible for payment. Refer to the [Filing Deadline](#) section of this chapter for more information.

[Payment policies](#) and [clinical coverage criteria](#) for specific services are available on the provider website. To ensure accurate claims processing, providers and their office staff must follow these documented policies.

Refer to [Avoiding Administrative Claim Denials](#) for tips to how to correct/avoid claim denials.

Methods for Claim Submission

Providers may submit claims electronically or on paper, as outlined below:

Electronic Claims

Providers may submit claims electronically via the following methods:

- **Secure Provider [portal](#)** — an online self-service tool that allows providers to check member eligibility, and check claim and prior authorization status. Providers may also check claim status and view claim details. For more details, refer to the [Provider Training Guides](#) page on our website.
- **Direct electronic data interchange (EDI) submission** — this method is ideal for submitting a large volume of claims. Submit electronic claims files through secure file transfers. Direct claims submission is free and offers customized reporting and increased control over testing and processing. For more information, email EDI_Operations@point32health.org or call **888-880-8699 x54042** to speak with an EDI specialist.
- **New England Healthcare Exchange Network (NEHEN)** — NEHEN is a consortium of regional payers and providers that offers a secure and innovative e-commerce solution for claims submission and other health care transactions. Visit NEHEN online for information on how to join or call 781-907-7210.
- **NEHENNet** — the NEHEN consortium collaborated on a single website called NEHENNet, which allows smaller practices and providers with less IT support to manage the most popular and essential transactions for a fixed monthly fee. For more information, visit NEHENNet, request an invitation to a weekly webinar via email at nehen-tech@nehen.org or call **781-907-7210**.
- **Clearinghouse submission** — we accept professional and institutional EDI claims via the MD On-Line clearinghouses. Update the clearinghouse with the Tufts Health Public Plans payer ID number: 04298.
- **ABILITY®** — for questions about setup and connectivity, visit ABILITY's website or call **888-499-5465**.
- **Other clearinghouses** — for questions about setup and connectivity to another clearinghouse, or how to appropriately configure the clearinghouse's software, email EDI_Operations@point32health.org or call **888-880-8699 x54042** to speak with an EDI specialist.

Submitting Electronic Claims

To submit claims electronically, providers must include the following:

- NPI number
- Tax ID number
- Payment address

Note: Claims with attachments (e.g. COB/TPL documentation, invoices, medical records) must be submitted as paper claims. Attachments are not accepted electronically.

Electronic Data Interchange Claims

Tufts Health Public Plans encourages direct electronic submission to the plan but also accepts claims submitted via a clearinghouse or ABILITY.¹ To be accepted, claims submitted directly to Tufts Health Public Plans 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 follow up on rejected claims.

When required information is missing, Tufts Health Public Plans or the clearinghouse will reject the claim. If an electronic claim is rejected, resubmit a clean electronic claim no later than 60 days from the date of service. For additional information, refer to [Avoiding EDI Claim Rejections](#).

¹ Professional claims only.

Refer to the [Electronic Services](#) section of the provider website to download a set-up form and companion documents for submitting claims electronically directly to Tufts Health Public Plans or contact Tufts Health Public Plans' EDI Operations Department by email at EDI_Operations@point32health.org or by phone at **888-880-8699, ext. 54042** for additional information about submitting electronic transactions or a setup request. For quality assurance purposes, providers must complete testing procedures. An EDI analyst will assist with coordinating the testing and implementation with the provider's organization.

EDI Referrals, Eligibility and Claim Status Inquiry

Tufts Health Public Plans offers options for electronic referrals, online eligibility inquiries and claim status information, as follows:

Referral	Web-based referral inquiry via the secure Provider portal
Eligibility	Web-based eligibility status via the secure Provider portal New England Healthcare EDI Network (NEHEN) Eligibility Inquiry and Response Integrated voice response (IVR) at 888-257-1985
Claim Inquiry Status	Web-based claims inquiry via the secure Provider portal NEHEN for Massachusetts providers only

Multiple Payees

For providers billing through EDI, Tufts Health Public Plans cannot accommodate payment to multiple payees at multiple payment addresses. Payment will be sent to the address listed as the primary provider's office location in the Tufts Health Public Plans provider database. Any address changes or primary vendor/payee changes should be submitted to the Provider Information Department by emailing Provider_Information_Dept@point32health.org or faxing a completed [Provider Information Change Form](#) to 857-304-6311.

Paper Claims

Industry-standard paper claim forms should be submitted for the following instances:

- Corrected claims (e.g. bill type 135 [late charges] and bill type 137 [replacement claim])
- Claims requiring additional supporting documentation, such as operative or medical notes (e.g. COB/TPL documentation or invoices, etc.)
- Claims for provider payment disputes
- Unlisted CPT procedures 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 submitted within 90 calendar days from the date of service for professional or outpatient services or within 90 calendar days from the date of discharge. Claims submitted by paper display on Explanation of Payment (EOP) Reports within 30 days.

Submitted paper claim forms should include all mandatory fields as noted in the [claims specifications](#) section of this chapter. Paper claim forms deemed incomplete will be rejected and a new claim with the required information must be resubmitted for processing.

Tips:

- 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, and practitioner's signature (CMS-1500 box #31)

Initial paper claims should be mailed to the following address:**Massachusetts and Rhode Island Paper Claim Submissions**

Tufts Health Public Plans – Paper Claims Submissions
P.O. Box 189
Canton, MA 02021-0189

Coordination of Benefits (COB)

Tufts Health Public Plans coordinates benefits when a member has additional insurance coverage (e.g., other primary insurance, third-party liability coverage).

Refer to the [Coordination of Benefits Payment Policy](#) for information on coordinating benefits for Tufts Health Direct members. **Note:** The Coordination of Benefits Payment Policy applies to all behavioral health services except for intensive care coordination (ICC) and family support and training (FS&T).

Federal and state regulations mandate that as a Medicaid managed care organization, Tufts Health Public Plans is payer of last resort for Tufts Health Together, Tufts Health RITogether and Tufts Health One Care. Providers must submit the claim(s) to all known available carriers as the primary insurer and receive an explanation of payment or equivalent, then submit the paper claim with the primary insurer's EOP to the secondary insurer (Tufts Health Public Plans). Do not take a cost-sharing amount up front.

If an attorney or insurance company other than Tufts Health Public Plans requests copies of a Member's medical records or bills, notify the Tufts Health Public Plans TPL recoveries team via fax at 857-304-6336.

When filing a claim for a Member with third-party resources:

- Attach documentation to the paper CMS-1500 or UB-04 form showing claims processing results from the primary payer. Claims with attachments must be submitted as paper claims. Attachments are not accepted electronically.
- Attach a copy of the TPL carrier's EOP, denial notice and benefits-exhausted statement to include both personal injury protection (PIP) and MedPay (auto insurance covering medical and funeral expenses resulting from an accident for the policyholder and any passengers riding with the policyholder) for claim payment.
- The primary insurance carrier's EOP must contain the date the claim was processed or the check date. Also, a description of any remark codes indicated on the EOP must be submitted. An administrative denial (claim preparation error or because sufficient information to process the claim was not received) from the primary carrier is not accepted as a reason for Tufts Health Public Plans to pay as a primary carrier.

When submitting a claims retraction request for a claim that a motor vehicle, workers' compensation, health, or other third-party insurer has paid, providers must include a copy of the primary carrier's EOP and, when applicable, a check.

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 Public Plans has outsourced subrogation recovery services to The Rawlings Company in Louisville, Kentucky. As a result, providers could receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries related to such claims should be directed to the Rawlings Company representative at the number indicated on the correspondence. All other subrogation questions must be directed to Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

Recovery of Overpayments

In accordance with federal and state laws, Tufts Health Public Plans recovers its overpayments to providers.

Claims Payment

Clean/Complete Claims

The Massachusetts Executive Office of Health and Human Services (MassHealth) defines a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It may include a claim with errors originating from a contractor's claims system. A claim is not clean if it comes from a provider who is under investigation for fraud or abuse, or if the claim under review for medical necessity. **Note:** The Rhode Island Executive Office of Health and Human Services uses the term "complete claim" instead of "clean claim".

Clean claims must be filed within the timely filing period with the appropriate CPT/HCPCS codes and any applicable modifiers. For information about the forms to use for submitting claims, refer to the [Claims 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 are members on the date of service
- Furnished by a provider eligible for payment under Medicare and/or Medicaid
- Provided or authorized by the member's PCP or the PCP's covering practitioner in accordance with the applicable benefit document, or as identified elsewhere in the provider's contract with Tufts Health Public Plans (if applicable)
Note: When applicable, Tufts Health Public Plans applies the appropriate PCP cost share based on the PCP specialty that the covering provider self-identifies for covering providers submitting claims for Tufts Health Direct members.
- Provided in the member's evidence of coverage document
- Medically necessary as defined in the Medicare and/or Medicaid coverage guidelines
- Tufts Health Public Plans received the claim within 90 days from the date of service or the date of discharge if the member was inpatient, or date of the primary insurance carrier's EOB
- Appropriately authorized in accordance with Tufts Health Public Plans' inpatient notification, precertification and prior authorization procedures
- Billed electronically according to HIPAA standards or on CMS-1500 and/or UB-04 forms with a valid CPT/HCPCS code for professional services billed by a hospital
- "Clean claims" do not include a claim from a provider who is under investigation for fraud or abuse

All services rendered to members must be reported to Tufts Health Public Plans as encounter or claims data. An encounter is a billing form submitted by capitated providers for tracking purposes. Claim forms are submitted by noncapitated providers for both payment and tracking purposes.

Explanation of Payment (EOP)

The Tufts Health Public Plans explanation of payment (EOP) is a weekly report of all claims that have been paid or denied to the provider. EOPs may be viewed electronically by logging on to [Payspan Health](#). If the explanation is unclear, contact Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

Electronic Remittance Advice (ERA)

Tufts Health Public Plans offers the 835 health care claim payment advice through [Payspan Health](#). This electronic remittance advice (ERA) includes paid and denied claims submitted either via Electronic Data Interchange (EDI) or on paper forms and uses HIPAA standard reason codes.

Registration and support questions for retrieving the ERAs from PaySpan Health and for ongoing support is handled by the Payspan Provider Services team who the provider may contact by email at providersupport@payspanhealth.com or phone at 877-331-7154, option 1 (Mon-Fri, 8 a.m. – 8 p.m. ET).

EDI 277CA

For claims submitted via direct EDI, providers will receive an electronic 277CA Health Care Claim Acknowledgment Report that will indicate if claims were accepted for processing or denied.

Claims that appear on the 277CA as rejected are not active for processing in Tufts Health Public Plans' claims system. Providers must correct and resubmit these claims within the timely filing limits or within 60 days from the date of the 277CA. If a claim is submitted within 60 days from the date of the 277CA, but 90 days or more past the date of service, resubmit on paper with a copy of the Tufts Health Public Plans 277CA. The claim may be denied if timely filing limits and these instructions are not followed.

For more information, refer to the [Standard Companion Guide](#) available through the [Provider Resource Center](#).

Requests for Claim Review

If a provider has provided services to a member and disagrees with a claim denial or needs to provide additional or corrected information, they may submit a request for claim review. Refer to [Avoiding Administrative Claim Denials](#) for tips to correct/avoid claim denials.

Corrected Claims

Corrected claims are submitted when the original claim has missing, inaccurate or invalid data. Providers may submit corrected claims electronically or through paper claim forms, in accordance with applicable industry standard guidelines such as the National Uniform Claim Committee (NUCC) billing guidelines, HIPAA EDI standards, and/or state and federal requirements for providers.

Providers may submit corrected claims electronically through the secure Provider Portal, EDI submission process or on paper, as outlined below.

Secure Provider Portal Online Adjustment Requests:

Registered providers may submit corrected claims or dispute a claim using Tufts Health Public 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 that the adjustment has been received. Refer to the [Provider Payment Dispute Policy](#) for more information on corrected claims and disputes.

Note: Some claims may not be adjustable on the Provider Portal. If a claim cannot be adjusted via the Provider Portal, a message will appear indicating the claim is not adjustable. In this instance, claim adjustments may be submitted on paper.

EDI Submissions:

To submit a corrected 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: Some claims may not be adjustable via EDI. If you receive a rejection report, please submit the claim adjustment on paper.

Paper Submissions:

A [Request for Claim Review Form](#) must be submitted with the corrected paper claim. To submit a paper corrected claim via paper:

- Print out or hand-write a new claim with corrected information
- Write “Corrected Claim” and the original claim number at the top of the claim
- Circle all corrected claim information
- Attach the Explanation of Payer (EOP) remit advice from the original claim
- Indicate the item(s) needing correction
- Highlight new or updated data elements on the claim

- **For Corrected Facility Claims:**
 - On the UB-04 (UB-04) 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).
 - Enter the original claim number in Box 64 (Document Control Number).

- **For Corrected Professional Claims:**
 - In Box 22 (Medicaid Resubmission Code) on the CMS-1500 form, enter the frequency code **7** under “Code.”
 - In Box 22, enter the original claim number under “Original Ref No.”
 - Refer to the [Request for Claim Review Form and Mailing Information](#) for the appropriate address to submit the claim in the time frame specified by the terms in the provider’s contract

Filing Deadline

The timely filing deadline for first time claims submissions is as follows:

If the provider is...	Submission Timeline
In state, in-network	90 days
Submitting a claim for a COB or TPL	60 days from the date on the original primary carrier’s EOP or third-party determination letter

The acceptable formats for filing proof of electronic submissions are either a rich text format (RTF) document or a 277CA transaction report to the direct submitter or clearinghouse that indicates the claim was submitted and accepted by Tufts Health Public Plans within timely filing limits.

Filing Deadline Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing deadline must be submitted within 60 calendar days of the EOP date on which the claim originally denied. Disputes received after 60 calendar days will not be considered. Disputes submitted via EDI will be rejected.

If the initial claim submission is after the filing limit and the circumstances for the late submission are beyond the provider’s control, the provider can submit a payment dispute for reconsideration. To do this, send a letter documenting the reasons why the claim could not be submitted within the contracted filing deadline, and include any supporting documentation and send a [Request for Claim Review Form](#).

Note: Submit documented proof of timely submission with any request for review and payment of a claim previously denied due to the filing deadline.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted through a clearinghouse or ABILITY, a copy of the transmission report and rejection report showing that the claim did not reject at the clearinghouse or at Tufts Health Public Plans (two separate reports)
- For claims submitted directly to Tufts Health Public Plans, the corresponding report showing that the claim did not reject at Tufts Health Public Plans
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify himself or herself as a Tufts Health Public Plans member at the time of service

For paper claim submissions, the following are considered acceptable proof of timely submission:

- Copy of patient ledger that shows the date the claim was submitted to Tufts Health Public Plans
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify himself or herself as a Tufts Health Public Plans member at the time of service

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 for claims should be sent to the following address:

Tufts Health Public Plans
Attn: Provider Payment Disputes
P.O. Box 524
Canton, MA 02021

Provider Payment Disputes

Providers have the right to file a payment dispute with a claim decision regarding the denial or compensation of a claim. Tufts Health Public Plans providers can submit a claim payment dispute using the claims adjustment tool on the secure Provider [portal](#) or on paper. Providers who are not registered users of the secure portal may go to the secure Provider [portal](#) and follow the instructions. Paper claim payment disputes should be submitted to:

Tufts Health Public Plans
Attn: Provider Payment Disputes
P.O. Box 524
Canton, MA 02021

Payment disputes must include a copy of the EOP, appropriate documentation and a completed [Request for Claim Review Form](#). Please include only one claim number per form. Multiple claim number 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.

Note: Payment disputes and corrected claims cannot be submitted via EDI.

Payment Adjustments

Tufts Health Public Plans adjusts claims when providers receive incorrect payments as a result of various issues including, but not limited to:

- Billing errors
- Duplicate payments
- Coordination of benefits
- Payments inconsistent with contractually allowed amounts
- Member disenrollment

Tufts Health Public Plans applies adjustments to future claims payments or requests refund checks from providers when appropriate. When the adjustment is applied to future payments(s), providers are notified via an explanation of payment. If an overpayment causes the adjustment and the retraction results in a negative balance, a provider does not receive additional payments until additional claims are received to offset the negative balance. Except for claims under investigation for fraud, waste and abuse, Tufts Health Public Plans does not initiate adjustments more than 24 months from the original Tufts Health Public Plans EOP date.

Returned Funds for Overpayment and/or Inappropriate Payment

Providers are required to return funds within 60 days of when they identify the receipt of overpayment and/or inappropriate payment. Providers must complete and submit a [Returned Funds Form](#) and payment EOP for claims requesting to be refunded to the Finance Services Team that the provider has identified as overpayment/inappropriate payment. Submitting funds without the form and supporting documentation can delay the process of having the funds allocated back to the appropriate provider's account.

Retroactive Denials (Tufts Health Direct, Tufts Health Together and Tufts Health One Care)

Tufts Health Public Plans may reprocess claims in accordance with our adjudication guidelines to ensure appropriate payment for services rendered. In accordance with [state law](#) governing Massachusetts-based fully insured commercial and Medicaid plans, Tufts Health Public Plans sends notification to behavioral health providers in Massachusetts and allows 30 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 days (15 days for coordination of benefits or worker's compensation claims), the claim will be readjusted and processed.

Member Enrollment Retroactivity (Tufts Health Direct, Tufts Health Together and Tufts Health RITogether)

Tufts Health Public Plans makes retroactive changes to member enrollment data based solely on information received from an applicable governing agency and readjudicates claims affected by these changes.

Tufts Health Public Plans identifies and readjudicates claims processed during the retroactive period. If another insurer has denied a claim for services rendered during the retroactive period, providers must submit the claim to Tufts Health Public Plans along with a copy of the other insurer's explanation of payment. Tufts Health Public Plans only reimburses services covered under the member's plan. Note: If prior authorization is required for services rendered during the retroactive period, providers must submit medical documentation to obtain authorization.

Member Responsibility

Tufts Health Public Plans in-network providers agree to accept payment in accordance with applicable fees, rates and amounts established under their provider agreements and applicable compensation regulations.

Members may not be billed for services that have been denied for exceeding the filing deadline or missed appointments.

Under the terms of providers' contracts with Tufts Health Public Plans, balance billing of members (i.e., attempted collection of fees for services other than a member's applicable cost share amount) is prohibited, and billing members for noncovered services is prohibited without an advance written agreement by a member to pay for the specific noncovered services. In accordance with the [Consolidated Appropriations Act, 2021](#) Tufts Health Direct members cannot be balance

billed and are only responsible for their in-network cost share for emergency services or services rendered by a non-participating provider at an in-network facility. Where a member has completed a consent form from a provider which satisfies the requirements of the Consolidated Appropriations Act, the member may be held financially liable for certain non-ancillary services rendered by a non-participating provider at an in-network facility.

Note: A general type of acknowledgement (e.g., “I agree to pay for anything that my insurance does not pay for”) is not considered adequate to confirm the member’s understanding and acknowledgement that it is not a covered service. Refer to the Forms section of the public Provider website for Tufts Health Plan’s [Agreement to Financial Liability](#) form.

Providers agree to not seek or accept payment from any member of Tufts Health Together ACPPs, Tufts Health Together MCO or Tufts Health RITogether for any MCO/ACPP covered service rendered, and providers agree to not make any claim against or seek payment from EOHHS for any MCO/ACPP covered service rendered to a member of Tufts Health Together ACPPs, Tufts Health Together MCO or Tufts Health RITogether. Instead, providers agree to look solely to Tufts Health Public Plans for payment with respect to MCO/ACPP covered services rendered to members of Tufts Health Together ACPPs, Tufts Health Together MCO or Tufts Health RITogether. Furthermore, providers agree they will not maintain any action at law or in equity against any member of Tufts Health Together ACPPs, Tufts Health Together MCO, Tufts Health RITogether or EOHHS to collect any sums that are owed by Tufts Health Public Plans under the contract for any reason, even in the event that Tufts Health Public Plans fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the agreement between the contractor and any network providers and non-network providers.

For Tufts Health One Care members, a provider may not charge members for any service that:

- is not a medically necessary covered service or non-covered service
- for which there may be other covered services or non-covered services that are available to meet the member’s needs
- that the provider did not explain the items above

Members cannot be held liable to pay for of any such services in which the provider did not discuss the above. The provider must document compliance with this provision.

Claim Specifications

Completing the UB-04 Form

Use the UB-04 form to complete a claim for institutional services. To complete this form, refer to the instructions in [UB-04 Claim Form Specifications](#) in this chapter. Field information is required unless otherwise noted. This form may be prepared according to Medicare guidelines as long as all required fields are completed. Follow these instructions to complete each hospital and facility claim accurately:

- Validate all procedure and diagnosis codes submitted for the date of service and bill to the fourth- and fifth-digit specification when appropriate.
- Include the prior authorization number on all inpatient submissions.
- Provide medical records to review upon request, for payment accuracy.
- **RITogether member claims:** Submit the attending/rendering physician’s name, NPI and Rhode Island license number on the claim form.

Completing the CMS-1500 (02/12) Form

Use the CMS-1500 (02/12) form to submit a 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 instructions in the [CMS-1500 \(02/12\) Claim Form Specifications](#) section.

Note: If unlisted or miscellaneous codes are used, notes and/or a description of services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment 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.

Figure 1: UB-04 Claim Form Specifications

Note: Mandatory fields are marked with M. Optional fields are marked with an O. The mandatory and optional fields may vary by state. Fields marked with an asterisk (*) are to be completed only if applicable.

Box	Field Name	MA	RI	Instructions
1	Untitled	M	M	Enter the name and address of the hospital/provider.
2	Untitled	M	M	Enter the address of payee (if different from the address in box 1).
3a-b	Patient control number	O	M	3a: Enter member account number. 3b: Enter medical record number.
4	Type of bill	M	M	Enter the 3-digit code to indicate the type of bill. Note: Claim will be returned if the type of bill is missing.
5	Federal tax number	M	M	Enter the hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.
6	Statement covers period	M	M	Enter the beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. <ul style="list-style-type: none"> For services received on a single day, both the “from” and “through” dates will be the same. If the “from” and “through” dates differ, these services must be itemized by date of service (see Box #45).
7	Untitled	N/A	N/A	Not applicable
8a	Patient ID and name	M	M	8a: Enter member ID number. 8b: Enter the member’s last name, first name and middle initial, if any, as shown on the member’s Tufts Health Public Plans member ID card.
9a-e	Patient address	M	M	Enter the member’s mailing address from the member record.
10	Birth date	M	M	Enter the member’s date of birth (MMDDYYYY).
11	Sex	M	M	Indicate Male (M) or Female (F).
12	Admission date	M	M	Enter date of admission/visit.
13	Admission hour	M	M	Enter the time (hour: 00–23) of admission/visit.
14	Admission type	M	M	Enter the code indicating the type of this admission/visit.
15	Source of admission (SRC)	M	M	Enter the code indicating the source of this admission/visit.
16	Discharge hour	M	M	Enter the time (hour: 00–23) the member was discharged.
17	STAT (Patient discharge status)	M	M	Enter the code to indicate the status of the member as of the through date on this billing. Interim billing is not allowed, and the member status cannot be member.
18-28	Condition codes	O	O	Enter the code used to identify conditions relating to this bill that can affect payer processing.
29	Accident state	M	M	Enter the state in which accident occurred.

Box	Field Name	MA	RI	Instructions
30	Accident Date	N/A	N/A	Date the accident occurred, if applicable (MMDDYY)
31-34	Occurrence codes and dates	M*	M*	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. Note: Tufts Health Public Plans requires all accident-related occurrence codes to be reported.
35-36	Occurrence span code and dates	O	M	Enter a code and the related dates that identify an event that relates to the payment of the claim.
37	Untitled	N/A	N/A	Not applicable
38	Untitled	N/A	N/A	Not applicable
39-41	Value codes and amounts	N/A	M*	<ul style="list-style-type: none"> Enter up to three value codes to identify circumstances that may affect processing of this claim, if applicable. In the amount box, enter the number, amount, or UCR value associated with that code.
42	Revenue code	M	M	Enter the most current uniform billing revenue codes.
43	Revenue description	M	M	Enter a narrative description that describes the services/procedures rendered. Use CPT-4/HCPSC definitions whenever possible.
44	HCPSC/rates	M	M	For outpatient services, use CPT/HCPSC codes for procedures, services and supplies. <ul style="list-style-type: none"> Do not use unlisted codes. If an unlisted code is used, then supporting documentation must accompany the claim. Do not indicate rates.
45	Service date	O	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	M	Enter the units of service rendered per procedure.
47	Total charges	M	M	Enter the charge amount for each reported line item. A negative amount will not be accepted.
48	Noncovered charges	O	M	Enter any noncovered charges for the primary payer pertaining to the revenue code.
49	Untitled	N/A	N/A	Not applicable
50a-c	Payer	M	M	List all other health insurance carriers on file. If applicable, attach an EOB from another carrier.
51	Health plan ID	O	O	List provider number assigned by health insurance carrier.
52	Rel. info (release of information)	N/A	M	Enter "Y" for yes or "N" for no.
53	Asg ben (assignment of benefits)	N/A	M	Enter "Y" for yes.
54	Prior payments (payer and patient)	M	M	Report all prior payment for claim. Attach EOB from another carrier, if applicable. A negative amount will not be accepted.
55	Est. amount due	N/A	N/A	Not applicable

Box	Field Name	MA	RI	Instructions
56	NPI	M	M	Enter valid NPI number of the servicing/rendering provider.
57a-c	Other Prv ID (another provider ID)	N/A	N/A	Not applicable
58a-c	Insured's name	M	M	Enter the name of the individual who is carrying the insurance.
59	P. Rel (patient's relationship to insured)	M	M	Enter the code indicating the relationship of the member to the identified insured/subscriber.
60a-c	Insured's Unique ID (health insurance claim/ID #)	M	M	Enter the member's Tufts Health Public Plans ID number, including the suffix, as shown on the member's Tufts Health Public Plans ID card.
61a-c	Group name	M	O	Enter the name of the group or plan through which the insurance is proved to the insured.
62a-c	Insurance group number	M	O	Enter the ID 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	M	Enter the Tufts Health Public Plans referral/authorization number for outpatient surgical day care services.
64a-c	Document control number	N/A	N/A	Not applicable
65a-c	Employer name	M*	M*	Enter the name of the employer for the individual identified in box 58.
66	DX version qualifier	N/A	N/A	Not applicable
67a-q	Principal diagnosis code	M	M	Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for the admission/visit. Codes must be to the appropriate digit specification, if applicable. If the diagnosis is accident-related, then an occurrence code and accident date is also required. Present on admission (POA) indicator should be entered as the 8th character.
68	Other diagnosis codes	M*	M*	Enter the ICD-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently. Code must be to the appropriate digit specification, if applicable.
69	Admit Dx	M	M	Enter the ICD-CM diagnosis code provided at the time of admission as stated by the provider.
70	Patient reason Dx	O	M	Enter the ICD diagnosis code that describes the patient's reason for visit.
71	PPS code (prospective payment system)	O	O	Optional
72	ECI (external cause of injury code)	M*	M*	Enter the ICD-CM code for the external cause of an injury, poisoning or adverse effect.
73	Untitled	N/A	N/A	Not applicable

Box	Field Name	MA	RI	Instructions
74a-e	Principal procedure code (code and date)	M	M	Enter the 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	N/A	Not applicable
76	Attending physician	M	M	Enter the ordering practitioner's NPI, last name, first name and middle initial.
77	Operating physician	M*	M*	Enter the name and NPI number of the practitioner who performed the principal procedure.
78-79	Other provider types	O	O	Optional
80	Remarks	O	O	Examples: "COB-related" or "billing for denial purposes only"
81a-d	ICC	O	M	<ul style="list-style-type: none"> Enter B3 in the qualifier if fields 76-79 contain an NPI. Enter the corresponding provider taxonomy of provider NPI's entered in locations: <ul style="list-style-type: none"> 76a – 81CCa 77b – 81CCb 78c – 81CCc 79d – 81CCd

Figure 2: CMS-1500 (02/12) Claim Form Specifications

Note: Mandatory fields are marked with M. Optional fields are marked with an O. The mandatory and optional fields may vary by state. Fields marked with an asterisk (*) are to be completed only if applicable.

Box	Field Name	MA	RI	Instructions
1	Type of insurance coverage	O	O	<ul style="list-style-type: none"> Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional. If the <i>Other</i> box is checked, complete Box #9.
1a	Insured's ID number	M	M	<ul style="list-style-type: none"> Enter the member's current identification number exactly as it appears on the member's Tufts Health Public Plans 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	M	Enter member's last name, first name and middle initial, if any, as shown on the member's Tufts Health Public Plans ID card.
3	Patient's birth date and sex	M	M	Enter member's date of birth and sex.
4	Insured's name	M	M	<ul style="list-style-type: none"> 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).

Box	Field Name	MA	RI	Instructions
5	Patient's address	M	M	<p>Enter the member's permanent mailing address and telephone number:</p> <ul style="list-style-type: none"> On the first line, enter the street address. On the second line, enter the city and state. On the third line, enter the zip code and telephone number.
6	Patient relationship to insured	M	M	Check the appropriate box for the member's relationship to the insured (self, spouse, child, other).
7	Insured's address	M	M	<p>If the insured's address is the same as the member's address, enter SAME.</p> <p>If the insured's address is different than the member's address, enter the insured's permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.</p>
8	Reserved for NUCC use	O	O	No entry required
9	Other insured's name	M	M	<ul style="list-style-type: none"> 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 the name of the other insured (last name, first name and middle initial).
9a	Other insured's policy or group number	M	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	O	No entry required
9c	Reserved for NUCC use	O	O	No entry required
9d	Insurance plan name or program name	M	M	Enter the 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	M	<ul style="list-style-type: none"> 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. Note: Claims with attachments cannot be submitted electronically. Enter the state postal code where the auto accident occurred.
10d	Claim codes	O	O	Enter up to 4 claim condition codes
11	Insured's policy group or FECA number	M	O	If the insured has other insurance, indicate the insured's policy or group number.
11a	Insured's date of birth and sex	M	O	Enter the insured's date of birth and sex, if different from the information in Box #3.

Box	Field Name	MA	RI	Instructions
11b	Other claim ID	M	M	<ul style="list-style-type: none"> 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	M	<ul style="list-style-type: none"> Enter the insurance plan or program name, if applicable. This field is used to determine if supplemental or other insurance is involved. If the supplemental or other insurer is a Blue Cross Blue Shield plan, enter the name of the state or geographic area. E.g., Blue Shield of [name of state].
11d	Is there another health benefit plan?	M	M	Check either 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	M	<ul style="list-style-type: none"> 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	M	<ul style="list-style-type: none"> 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	M	<ul style="list-style-type: none"> Enter date of current illness, injury or pregnancy in the designated MMDDYY space. Enter the qualifier found in the 837 electronic claim to the right of the QUAL dotted line.
15	Other date	O	O	<ul style="list-style-type: none"> Enter the qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL. Enter the date in the designated MMDDYY space.
16	Dates patient unable to work in current occupation	O	O	If the member is unable to work in his or her current occupation, enter the dates. An entry in this box could indicate employment-related insurance coverage.
17	Name of referring provider or other source	O	M	<p>Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line.</p> <p>Enter the name of the referring and/or ordering practitioner or other source if the member:</p> <ul style="list-style-type: none"> 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

Box	Field Name	MA	RI	Instructions
17a-b	ID number of referring physician	O	M	<ul style="list-style-type: none"> Enter the 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	O	Enter the 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	O	Enter additional claim information.
20	Outside lab	O	O	Check YES or NO to indicate if laboratory work was performed outside the practitioner's office.
21	Diagnoses	M	M	Enter the diagnosis/condition of the member indicated by ICD-CM code number. Enter up to 12 codes in priority order (primary, secondary condition). Codes are arrayed across the box.
22	Resubmission code	O	M*	This item identifies a resubmission code.
23	Prior authorization number	O	M*	If applicable, enter the inpatient notification number.
24a	Date(s) of service	M	M	<ul style="list-style-type: none"> Enter the 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	M	Enter the appropriate place of service code.
24c	EMG	N/A	M*	Check this item if the service was rendered in a hospital or emergency room.
24d	Procedures, services or supplies	M	M	Enter valid CPT/HCPCS procedure codes and any modifiers.
24e	Diagnosis pointer	M	M	<ul style="list-style-type: none"> Enter the 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. Enter a maximum of four letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	\$ Charges	M	M	Enter the charge for each listed service.
24g	Days or units	M	M	Enter the days or units of service rendered for the procedures reported in Box 24d.
24h	EPSDT family plan	O	M*	Check this box if early and periodic screening, diagnosis and treatment, or family planning services were used.

Box	Field Name	MA	RI	Instructions
24i	ID QUAL	O	O	Check this box 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	M	If the rendering practitioner is not the billing practitioner, enter the rendering practitioner's NPI number.
25	Federal Tax ID number	M	M	Enter the practitioner/supplier's federal tax ID, employer ID number or Social Security number.
26	Patient's account number	O	O	Enter the 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	M	Check YES or NO to indicate whether the practitioner accepts assignment for the claim. By accepting assignment, the practitioner agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter.
28	Total charge	M	M	Enter the total charges for the services (i.e., the total of all charges in Box 24f).
29	Amount paid	M	M	<ul style="list-style-type: none"> Enter the 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).
30	Reserved for NUCC use	O	O	No entry required
31	Signature of physician or supplier, including degrees or credentials	M	M	<ul style="list-style-type: none"> 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	M	If other than home or office, enter the name and address of the facility where services were rendered to the member: <ul style="list-style-type: none"> Enter the NPI number for the facility Enter other ID number, if applicable
33, 33a	Billing provider info and phone	M	M	<ul style="list-style-type: none"> 33: Enter the name and payment address of the entity receiving payment. This must match the Tax ID and name on file with the IRS. 33a: Enter the NPI number for the entity receiving payment.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care
03/01/24	Updated box 45 in the UB-04 Claim Form section to optional in Massachusetts
04/01/24	Updated Corrected Claims section; administrative edits.
04/04/24	Administrative edits to Corrected Claims section