Webinar # 7
HRSN Claims 201

November 7, 2024

Agenda

Topic	Time
Welcome, Introductions and Recap of HRSN Webinars to Date	*5 mins*
Overview of Claims Submissions Process	*8 mins*
Step One – Determine How to Submit	*5 mins*
Step Two – Gather Information	*10 mins*
Step Three – Submit and Document	*10 mins*
Step Four – Payment or Work your Denials	*10 mins*
Q&A and Closing	*10 mins*

Recap of HRSN Webinars to Date

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Topic
Webinar 1 (March 2024) Transition from Flex Services to Managed Care Health-Related Social Needs (HRSN) Framework
Webinar 2 (May 2024) Becoming an HRSN Provider – Contracting, Credentialing, & Enrollment
Webinar 3 (May 2024) How to Apply for a National Provider Identifier (NPI)
Webinar 4 (June 2024) Hubs & Third-Party Options to Support HRSN Transition
Webinar 5 (August 2024) Understanding Claims & Billing as an HRSN Provider
Webinar 6 (October 2024) Financial Management in a Medicaid Environment

Overview of Claims Submission Process

Deep Dive

The 4 Steps of the Claims Submission Process

The Claims Submission process can be broken down into four steps:

1. Determine How to Submit
- Decide how you will submit your claims – paper; electronically; Direct Data Entry
- After you settle on a method, this step is done, though you may reconsider submission methods when appropriate

2. Gathering Information
- Member info; Provider info; Service info (correct coding)

3. Submit and Document
- Ensure you 'scrub' your claim before submission to ensure accuracy
- Document each claim submission. Ensure a copy of the claim as well as any receipts are kept and easily accessible
- Monitor your submission

4. Payment *or* Work your Denials
- The process is not complete until you receive payment or get a 'hard' denial that cannot be corrected

Owning the Process

Ensuring Accountability

- Different staff or team members may be involved in the process

  - Communication and Documentation is the key to success!

- Assigning one "owner" of the process is necessary

  - This can be an Office Manager; Biller; Director of Accounts Receivable; etc.

  - Even if you outsource your claims submission process to a vendor or hub, having an accountable "owner" who works with that vendor/hub to ensure follow-through and accuracy is helpful

  - The "owner" understands and utilizes a service documentation process, whether an Electronic Health Record (EHR) software system or a paper file system

  - The "owner" maintains a tracking system that monitors each claim from "soup to nuts" to ensure minimum losses or write-offs (could be part of the EHR or even a simple spreadsheet)

Traits the "Owner" Should Encompass

Whoever owns the claims submission process in your organization (whether that's an Office Manager, a Professional Biller, a Director of Accounting, etc.) should have the following traits:

- Attention to detail

- Follow-through/tenacity

- Organized / ability to create processes and workflows
    - Must utilize resources published by MassHealth or the contracted plan(s), or create needed resources
    - Must develop and maintain relationships with the contracted plan(s) for which your organization is providing services
    - Must be able to navigate differences in policies and procedures of the various plans with which your organization has contracted

MassHealth is administered by various plans and partners. You must familiarize yourself with the policies and procedures of all the contracted plan(s) your members may be enrolled with.

Step One-Claims Submission Process

Deep Dive

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Step One – **Determine How to Submit**

Claims *must* be submitted through one of three methods:

Paper Claims (CMS 1500 02-12) -Can be mailed to a designated mailing address published in the MCE's Billing Manual. Blank 1500 Forms may be properly completed using black 10-12-point font typed in capital letters. Do not use bold print. You can purchase blank 1500 Forms from suppliers such as Amazon, office supply stores, or other local printing companies in your area. There are options available online for Fillable CMS 1500 Forms to download, complete, and save. Note: paper claims have a longer processing time than the submission processes listed below.

Direct Data Entry (DDE) – Certain MCEs offer options to submit claims using this method in which you can enter all the claim information through their portal. This option may vary depending on the MCE; therefore, it is always best for HRSN Providers to consult with the Health Plan to verify whether this method is available.

Electronic Claims Submission – The 837P (Professional) is the standard industry format used by health care professionals and suppliers to transmit health care claims electronically. Although this claim transaction is standardized, it is best to obtain the electronic specifications from each ACO. Note: The 837P does require a special system that must be purchased and set up.

Decide on a Main Method and a Back-up Method
- May be different per plan depending on what the plan accepts; the usability of DDE options; etc.
- Learn at least two methods so you always have a back-up.

Step One – **Working With the Plans**

Contracting with the plans – the time to determine how you will submit claims begins with contracting!

During the contracting process, ask the specific plan:

- What methods of claims submission does the plan accept? What are the details?*
    - If it's a paper claim, what is the mailing address? Is secured fax an option? Etc.
    - See Appendix for Allowable Methods & Timeline of Claims Submission-HRSN Supplemental Services
- Does the plan offer training materials/resources for each method that they accept?
    - If the plan offers DDE through a provider web portal, do they offer training /resources on how to use the portal?
    - Is there an EDI Manual, 837p Companion Guide, or helpdesk to assist with electronic claims submission?
- Who is the specific contact to assist with claims submission setup?
    - See Appendix for Plan contacts, but it may be helpful to verify

Step Two-Claims Submission Process

Deep Dive

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IN ACTION

Step Two – **Gathering Information**

- There are three categories of information needed to submit a claim:

  1. Member Info

  2. Provider Info

  3. Service(s) Info

- All three categories of information may change, so the owner of the claim submission process must keep up-to-date on any changes.

- The "source of truth" for each category of information is the specific plan you are submitting the claim to:

  - You would *not* verify information with Tufts when you are submitting the claim to Fallon

  - Plans may have slight differences, so attention to detail is necessary (e.g., for provider address, one plan may require "SUITE" where a different plan may require "STE")

Step Two – **Member Information**

It is important to remember that *all member information is Protected Health Information (PHI)!* Ensure you have protocols in place to protect this information! (i.e., follow the "HIPAA Minimum Necessary Rule"- HIPAA covered entities are required to make reasonable efforts to ensure that uses and disclosures of PHI are limited to the minimum necessary information to accomplish the intended purpose of a particular use or disclosure.).

- Required member information includes:

  - Patient's Insurance I.D. Number

  - Patient's Name – last name, first name, middle initial (if applicable)

  - Patient's Address – street, city, state, zip code

  - Patient's Telephone – including area code

  - Patient's Birth Date and Sex – in MM/DD/YYYY format for all DOB fields; currently only choices for "Sex" are "M" or "F"

- The most accurate source of member information is the member's plan:

  - The Insurance Card issued by the plan will list the insurance I.D. number

  - Utilize this number, plus name and DOB if necessary, to pull up the member's data in the plan's eligibility portal

  - Ensure you understand the plan's specific benefit package – call the plan if you have questions

Step Two – **Member Information**

Examples of plan-issued insurance cards:

Use the name and ID number to pull up the member in the plan's (or appropriate vendor's) eligibility system and verify the member's coverage, spelling of their name, address, phone, etc. If questions arise, call the customer service number on the back of the plan-issued insurance card.

Step Two – **Member Information**

- You may also develop a "New Patient Form" or "Member Registration Form" where you list the information from the plan's eligibility system in an easily accessible format

- Keep this form, as well as a copy of the member's insurance card (front and back), in a **secured** member file

- For every service, verbally verify with the member if anything has changed **and** verify eligibility with the plan. Every couple of months or so, ask to see the card again to verify the information and any changes

Step Two – **Provider Information**

Required provider information includes:

- Organization name and address

- National Provider Identifier (NPI)

- Tax I.D. Number

- Taxonomy Number

- Patient's Account Number (provider's internal tracking number; operationally this number is replaced by the plan-assigned claims number or Internal Control Number (ICN) after the claim is submitted)

Step Two – **Service Information**

Every service interaction is billed through a set of codes. This set of codes includes:

- **Service or billing code** (for HRSN, this will be a Health Common Procedure Coding System (HCPCS) Level II code)

- **Modifier(s)**, if required

- **ICD-10 diagnosis code**

- **POS code (place-of-service)**

- *The best resources for required coding are your* <u>*HRSN Service Manuals and Fee Schedule*</u> and any plan-specific instructions you receive from a plan.

  The below perhaps a snapshot of the information that can be found in the Fee Schedule.

Service Name/ Description: name and description (as needed) of service	Description of specific code & modifier combination	HCPCS / Service Code: billing codes for this service	Modifier 1 (if applicable): first modifier to HCPCS / Service Code	Modifier 2 (if applicable): second modifier to HCPCS / Service Code	ICD-10 Diagnosis Code(s): codes for HRSNs addressed with this service	Unit of Service: service unit	HRSN Supplemental Fee Schedule: Maximum	Maximum Units
Healthy Homes - Goods	Allowable Healthy Homes goods that improve the air quality of the housing, allow the member to store and use needed medicine, or allow for improved pest control	**H0044**	**U2**	-	**Z59.10**	1 unit = 1 receipt for goods	$750	Multiple units allowed until the member reaches $750 maximum. Available once through 12/31/2027.

Step Two – **Service Information**

Your HRSN Service Manuals and Fee Schedule will tell you:

- The required order of modifiers – E.g., if one or more modifiers are required, which modifier must be listed as primary, which modifier must be listed as secondary, etc.

- The required ICD-10 "Z" diagnosis code to use, or a list of "Z" codes to choose from

POS codes indicate where the service took place. For HRSN services, the most used will probably be **12 – Home**; **11 – Office**; and **10 – Telehealth Provided in the Patient's Home**.

- A list of POS codes can be found at Place of Service Code Set | CMS

- See Appendix for: Recommended Place of Service Codes: HRSN Supplemental Nutrition Services

Step Two – **Service Information**

- Ensure you understand the unit definition of the specific service you are billing for. All claims must include a number in the "DAYS OR UNITS" field (Box 24.G on the CMS 1500 form). Examples include:

  - 1 unit = 1 receipt for goods
  - 1 unit = 30 days

- You must also include the Charged Amount, or the specific cost of the service or goods, on the claim in the "Charges" field (Box 24.F on the CMS 1500 form)

  - It is **vital** that you track the charged amount / paid amount, **especially** for services that have a maximum aggregate amount
  - We recommend you keep a copy of every claim submitted. Attach all pertinent receipts or other documents that provide justification for the service submitted on the claim and keep them in a secured location (member file, etc.)

Step Three-Claims Submission Process

Deep Dive

Step Three – **Submit and Document**

- Ensure claims are "scrubbed" before submission:

  - A "Claims Scrubber" is usually a software program that is part of an EDI system that reviews claims for any errors before submission, but it can also be done manually by a staff member

- Manual "claims scrubbing" – there are two types of scrubbing:

  - Auditing for complete information – E.g. are all the required fields filled out?

  - Auditing for accuracy -- are the codes, date of service (DOS), and charged amount accurate?

- Claims scrubbing means having at least one additional set of eyes reviewing the claim before submission.

- Ensure claims are submitted on time!

  - All plans have a "timely filing" rule, requiring claims to be submitted within 90 calendar days of the DOS

  - Some plans allow for 120 calendar days, but within 90 calendar days will provide a consistent target

  - The sooner you submit a claim, the sooner you can be paid

Step Three – **Submit and Document**

- For each claim submitted, there should be documentation so that paid claims match to provided services.

- It is recommended that you maintain individual or family member files, which include:

  - A copy of the insured member's ID card (front and back) and a <u>"New Patient Form"</u> or <u>"Member Registration Form"</u> that lists the required demographic information

  - A copy of each claim submitted with any attached receipts if appropriate

  - An ongoing list of services provided, with dates-of-service and/or modality/duration listed as well as itemized costs of services and goods

- A good question to consider is… *"if I were audited or had to prove that a service paid for by a claim did in fact happen, do I have the documentation to back it up?"*

- Consider developing an internal audit process that occurs every quarter or so.

Step Four-Claims Submission Process

Deep Dive

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Step Four – **Payment or Work Your Denials**

Once you have submitted the claim, it's not over yet! The process is incomplete until you receive payment or a "hard" denial. Making corrections and resubmitting the claim may be necessary

- Each plan that you have submitted claims to will produce a document, variously called a Remittance Advice (RA); a Provider Summary Voucher, or an Explanation of Benefits (EOB).
    - This is usually made available to providers on a weekly basis and will list out the adjudication activity for the previous week
    - This document will list each claim that was processed during that week:
        - If the claim was paid, it will list the payment amount
        - If the claim was denied, it will list an EOB Code or a Reason Code
- If you had any claims that were denied, then now it's time to "work your denials"
    - i.e. research why the claim was denied, and if correctable, correct the error and resubmit

Example of a Remittance Advice (RA)

All Insurance Company
10 Corporate Blvd.
Anywhere, MA 02010

Provider Remittance Advice

RA Date: 02/18/25
Provider Name: Springfield Social Services
Provider NPI: 1234567890
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--ICN--	MEMBER NAME	MEMBER NO.	SERVICE DATES	SERVICING PROV NPI
2025010111222	JOHN DOE	100111222333	011025 – 011025	1234567890

PROC	MODIFIERS	POS	UNITS	DIAG	BILLED AMT	ALLOWED AMT	COPAY/MEM LIAB	PAID AMT	DETAIL EOB
H0044	U2	12	1	Z5910	65.88	750.00	0.00	65.88	

--ICN--	MEMBER NAME	MEMBER NO.	SERVICE DATES	SERVICING PROV NPI
2025010111234	JOHN DOE	100111222333	010825 – 020825	1234567890

PROC	MODIFIERS	POS	UNITS	DIAG	BILLED AMT	ALLOWED AMT	COPAY/MEM LIAB	PAID AMT	DETAIL EOB
T2038		11	1	Z5902	400.00	0.00	0.00	0.00	S9

TOTAL PAID AMT
65.88

EOB CODE	EOB CODE DESCRIPTION
S9	NO FEE SCHEDULE FOUND

Step Four – **Payment or Work your Denials**

- Looking at this example of an RA – you had one claim pay, and one claim deny for "S9 – FEE SCHEDULE NOT FOUND".

- "S9 – FEE SCHEDULE NOT FOUND" is not an obvious reason, so you call the insurance plan to get the specific reason the claim was denied;

  - When you call the Customer Service Department of a plan to ask about a claim denial, you need to have handy the following information:

    - Provider Name and NPI

    - Member ID Number

    - *Plan assigned* claim number or ICN number, used to track claims (pulled from the Remittance Advice)

- The Customer Service Representative informs you that the claim could not map to the correct fee schedule because it is missing the required modifier of UD.

Step Four – **Payment or Work Your Denials**

- When resubmitting the claim, you add the required UD modifier and follow the plan's direction on filling in Box 22 – RESUBMISSION CODE I ORIGINAL REF NO

  - If the plan requires Box 22 to be filled out for resubmissions, **use number 7** as the resubmission code ("Replacement of prior claim") and **put the original claim's ICN number** as the REF NO

- If resubmitting through DDE, some plan's portals may allow you to "edit" the original claim by simply adding the required modifier and resubmitting.

Working your denials is the key to maximizing revenue and ensuring you get paid for all services rendered. Most plans have a time limit on resubmissions, so start working on your denials as soon as you receive your weekly Remittance Advice.

Step Four – **Payment or Work Your Denials**

- "Hard" denials refer to claims that cannot be corrected and resubmitted for payment and must be "written off". Examples include:

    - The member is not eligible on the date of service

    - The plan does not cover that specific benefit

    - The benefit is covered, but the benefit limit has been exceeded

The best way to combat "hard" denials is ensuring thorough front-end work verifying member eligibility and benefits and tracking all expenditures against any aggregate amount limits.

Other Suggestions

- Most insurance plans will pay claims through direct deposit

  - Signing up for direct deposit allows for quicker payment and eliminates tasks like depositing paper checks at the bank

- Obtain log-in credentials and familiarize yourself with plan websites

  - Many plans will offer plan-specific training webinars on topics such as claims submissions and provider portal utilization; as well as general training webinars on topics such as cultural competency and member engagement. Take advantage of these when possible

Questions

Thank You.

HRSN Provider Resources

- HRSN Integration Funds Website –For all previous presentations and additional information- https://hria.org/tmf/hrsn-integration-fund

- HRSN Services Manual -https://www.mass.gov/info-details/information-for-masshealth-acos-and-hrsn-providers?auHash=R8HaWRSTfMc-Ish0kn4ZHllMsiS3VS8SiNR-YP2WtPQ

- National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual- https://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2023_07-v11.pdf - National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual

- CMS Place of Service Code Set- https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets - CMS Place of Service Code Set

- HRSN Public Facing Sign Up Sheet-Hubs.

Points of Contact for Claims Inquiries

The points of contact below are for each health plan that potential HRSN Providers should contact with questions or support regarding claims setup and configuration (e.g. claims submission process, access to DDEs, health plan-specific training, etc.)

Health Plan	Key Contact	Email Address
WellSense	Lori Marshall	lori.marshall@wellsense.org
	Naomi Lisan	naomi.lisan@wellsense.org
Tufts / Point32	Provider Account Management Team	BHPAM@point32health.org
Health New England (HNE)	Preeti Nakrani	pnakrani@hne.com
	Kerry LaBounty	klabounty@hne.com
Fallon Health	Christa Diaz	christa.diaz@fallonhealth.org
Mass General Brigham (MGB)	David St. Pierre	dstpierre2@mgb.org
Massachusetts Behavioral Health Partnership (MBHP)	Jennifer LaRoche	jennifer.laroche@carelon.com

ACO Customer Service Number and Hours of Operation

Health Plan	Customer Service Number	Hours of Operation
WellSense	888-566-0010 (TTY:711)	Mon-Fri, 8am-6pm (closed Thurs from 2:30pm-3:30pm)
Tufts / Point32	888-257-1985	Mon-Fri, 8am-5pm
Health New England (HNE)	Direct line:413-788-0123 Toll Free: 800-786-9999	Hours of Operation: Mon-Fri, 8am-5pm Member Service Hours: 8am-6pm
Fallon Health	855-508-3390	Mon-Fri, 8am-6pm
Mass General Brigham (MGB)	800-462-5449	Mon-Fri 8am-6pm, Thurs 8am-8pm
Massachusetts Behavioral Health Partnership (MBHP)	800-495-0086	

Allowable Methods & Timeline of Claims Submission-HRSN Supplemental Services

Managed Care Entity	Method for Submitting Claims	Timeline for Claims Submission (initial submission, in calendar days)
WellSense	Paper Claims, Electronic Claim Submission (highly recommended), DDE	120 Days
Tufts/Point 32	Paper Claims, Electronic Claim Submission, DDE	90 Days
Health New England (HNE)	Paper Claims, Electronic Claim Submission, DDE	90 Days
Massachusetts Behavioral Health Partnership (MBHP)	Paper Claims, Electronic Claim Submission, DDE	90 Days
Fallon	Paper Claims and Electronic Claim Submission (DDE anticipated to be available sometime in 2025)	120 Days
Massachusetts General Brigham (MGB)	Paper Claims, Electronic Claim Submission, DDE	90 Days

Recommended Place of Service Codes: HRSN Supplemental Nutrition Services

These codes are recommendations. MassHealth recognizes that services may be provided elsewhere. Providers should use the code that best describes the POS.

POS 12: Home
- Medically Tailored Meals
- Home Delivered Meals
- Medically Tailored Food Boxes
- Nutritionally Appropriate Food Boxes
- Medically Tailored Food Prescription and Voucher Program
- Nutritionally Appropriate Food Prescription and Voucher Program
- Kitchen Supplies

POS 10: Telehealth Provided in Patient's Home
- Nutrition Class
- Nutrition 1:1 Education
- Nutritional Counseling, diet

POS 11: Office
- Nutrition Class
- Nutrition 1:1 Education
- Nutritional Counseling, diet

POS 99: Other Place of Service
- Services provided at a Nutrition Hub (grocery store; food mart; farmers market)

Full 1500 Billing Form

Box 1 – Check off Medicaid
Box 1a – Insured's ID Number
Box 2 – Insured' Name
Box 3 – Insured's Date of Birth and Sex
Box 4 – Insured's Name
Box 5 – Insured's Address
Box 6 – Check off Self
Box 7 – Insured's Address
Box 10a-c – Check off No on all
Box 11a – Insured's Date of Birth and Sex
Box 11d – Check off No
Box 12 & 13 – Notate Signature on File

Box 22 - Resubmission Code-is a code an HRSN Provider will add if the original claim that was submitted is denied
Box 21 A-L List the ICD10 Diagnosis codes that correspond with the services

Box 24A – Line 1 – List the Date of Service
Box 24B – Line 1 – List the Place of Service
Box 24D – Line 1 – List the HCPC and Modifiers
Box 24E – Line 1 – List the Diag pointers
Box 24F – Line 1 – Enter the Cost for the service
Box 24G – Line 1 – Enter the Number of Units
Box 24J – Line 1 – Enter the Taxonomy code in Shaded Area
Box 24J – Line 1 – Enter the NPI
If Insured has more services; mimic the process for lines 2-6

Box 25 – Providers Tax ID Number – Check off EIN
Box 26 – Internal Claim Number Provider Created
Box 28 – Total amount of Cost
Box 31 – Type Authorized Representative and Date
Box 32 – Providers Name & Address – 32a – Provider's NPI
Box 33 – Providers Name & Pay to address – if you have PO Box – this is where you would want to enter it. 32a – NPI & 32b Tax ID #

Completing the CMS 1500 Billing Form

1) **Fill out all of the information listed below:**

John, a MassHealth member eligible to receive HRSN service met with staff at our organization. We are now preparing a claim for those encounters.

In Box 1a – Insured's ID Number, we verified and entered John's insurance ID number.

Next, we verified John's demographic information (Boxes 2-5) to ensure that we enter this information as the MCE has it on file.
- **Box 2- Insured's Name**
- **Box 3 - Insured's Date of Birth and Sex**
- **Box 4 - Insured's Name**
- **Box 5 - Insured's Address**

For Box 6-Patient Relationship to Insured, we checked off 'Self' and added John's home address and phone number again in Box 7.

Box 10a-c - Check off 'No' on all.

We entered John's date of birth and sex in Box 11a and checked off 'No" for Box 11d .

Finally, in Box 12 & 13 we Notate Signature on File.

Completing the CMS 1500 Billing Form

2) In Boxes 14-19, 16-20 and 23, HRSN Providers will not need to fill those areas.

- **Box 22 - Resubmission Code-is a code an HRSN Provider will add if the original claim that was submitted is denied.**

- **In Box 21 A-L , we listed John's ICD-10 Diagnosis code or HRSN condition that corresponds with the services we provided to him. In this case Z59.41 in the HRSN Service Manual is the code for HRSNs addressed with this service**

Completing the CMS 1500 Billing Form

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER						
															133N00000X
1 01	01	24	01	01	24	10		S9452		A	180.00	2		NPI	9875643210
															133N00000X
2 01	02	24	01	02	24	10		S9452	U1	A	90.00	1		NPI	9875643210
															133N00000X
3 01	03	24	01	03	24	10		S9452	U2	A	90.00	1		NPI	9875643210
4														NPI	
5														NPI	
6														NPI	

3) Fill out the following information:

- In Box 24A – Line 1 – we added all the Dates of Service, for each encounter that we had with John . In this example we met with him on three occasions and provided two units of service during one encounter (2 nutrition education classes).

- Box 24B – Line 1 –Place of Service

- In Box 24D – Lines 1 -3 we went into the HRSN Service Manual and included the HCPCS and Modifiers for each of the encounters we had with John.

- Box 24E – Line 1 -3 – The Diagnosis pointers-The diagnosis pointer should reference the diagnosis that the service relates to.

- We listed the cost or charged amount for the services rendered to John in Box 24F – Lines 1-3. The rates listed are based on the ACOs rates.

- In Box 24G – Line 1 –3, we've listed the Days or Number of Units for John's encounter with us.

- HRSN Taxonomy codes can be found in the NPI Taxonomy Codes Reference for MassHealth Services document. We used this to fill out Box 24J – Lines 1–3 Taxonomy code shaded area

- Finally, we used our organization's unique NPI number in Box 24J – Lines 1 –3

- **If the HRSN Provider is billing for additional services the Insured received, mimic the process for lines 2-6**

Completing the CMS 1500 Billing Form

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOT
012345678	X	JD12345	YES NO	$

| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

Jane Smith

01/10/2024
SIGNED   DATE | 32. SERVICE FACILITY LOCATION INFORMATION
Food Pantry
123 Red Road
Boston MA 02111-1111
a. 9876543210   b. EI012345678 | 33. BILL
Food Pa
PO Box
Boston
a. 987 |

NUCC Instruction Manual available at: www.nucc.org   PLEASE PRINT OR TYPE

4) Complete the following information:

In Boxes 25-26, and Boxes 31-33 we are filling out our organization's information.

- **Box 25 – Provider's Tax ID Number – We checked off 'EIN' and entered our organization's Tax ID #.**

- **Box 26 – Internal Claim Number (Provider Created)- we entered our ICN, the tracking number for John's claim.**

- **Box 28 – Total Amount of Cost, we entered the total charged amount for HRSN services rendered to John.**

- **Box 31 – We entered our organization's Authorized Representative , Jane Smith and the date.**

- **Box 32 – We entered our organization's name & address . In Box 32a we added our organization's NPI # and in Box 32b, we added our Tax ID numbe**
    - **32a – NPI & 32b Tax ID #- We entered our organization's name and address, the NPI # for the service we provided to John and our Tax ID again.**

- **Box 33 – We entered our organizations name and address where payment should be sent to. In our case, we sent it to our PO. Box (If you have a PO Box, enter it here.) In 33a, we entered our NPI and Tax ID # once again.**