

Claim Requirements and Dispute Guidelines

General Guidelines

Tufts Medicare Preferred processes completed claims that meet the conditions of payment and that are submitted within the time frame identified in your agreement with Tufts Medicare Preferred. *Completed claims* are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately (see [Claim Specifications](#)). Claims must be submitted within the contracted filing limit according to the date of service, date of discharge, or date of the primary insurance carrier’s explanation of benefits (EOB). Tufts Medicare Preferred will deny claims submitted after the filing limit, and the Member is not responsible for payment. See [Filing Limit](#) for more information.

Additional guidelines, payment policies, and clinical coverage criteria for specific services are available on the Tufts Health Plan Web site. To ensure accurate claims processing, it is recommended that providers refer to the [Payment Policies](#) on our Web site. For initial claims submission and additional information, see the Tufts Health Plan [Claims Submission Policy](#) and tips for [Avoiding Administrative Claim Denials](#).

Electronic Data Interchange Claims

Tufts Medicare Preferred encourages direct electronic submission to the plan, but also accepts claims submitted via a clearinghouse. Claims submitted directly to Tufts Medicare Preferred must be in HIPAA-compliant standard 837 format and include all required information to be accepted. Refer to our [837 companion document](#) for additional information. All methods of 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 Medicare Preferred 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 our [Electronic Claims Submission Policy](#) and [Avoiding EDI Claim Rejections](#).

For more information about submitting electronic transactions, contact Tufts Health Plan's EDI Operations Department via email at EDI_operations@tufts-health.com or by phone at 888-880-8699, ext. 3344 for a set-up request. You can also visit the [Electronic Services](#) section of our Web site to download a set-up form and companion documents for submitting claims electronically directly to Tufts Medicare Preferred.

EDI Referrals, Eligibility and Claim Status Inquiry

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

Referral	<ul style="list-style-type: none"> • Web-based referral inquiry via the Tufts Health Plan Provider Login. • ANSI 278: Request for Review and Response for outpatient referrals – standardized referral submission format, currently available through NEHEN.
Eligibility	<ul style="list-style-type: none"> • Web-based eligibility status via the Tufts Health Plan Provider Login. • Status information via Emdeon POS Device: facilities data input and status retrieval. • NEHEN Eligibility Inquiry and Response. • IVR (Integrated Voice Response) at 1-888-884-2404.
Claim Status Inquiry	<ul style="list-style-type: none"> • Web-based claims inquiry via the Tufts Health Plan Provider Login. • NEHEN.

Multiple Payees

For providers billing through EDI, Tufts Medicare Preferred 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 Medicare Preferred provider database. Any address changes or primary vendor/payee changes should be submitted in writing to the Tufts Health Plan Provider Information Department.

Paper Claims

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

- Claims requiring additional supporting documentation, such as operative or medical notes.
- Claims for provider payment disputes.
- Services with zero amount billed (except Ambulatory Surgical Claims).
- Unlisted CPT procedures that require explanations or descriptions.

Paper Claim Submission Requirements

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 and a letter stating the reason for rejection will be returned to the submitter, 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 4 diagnosis codes will be accepted on the CMS-1500 form.
- 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)

Paper claims should be mailed to the following address:

Tufts Health Plan Medicare Preferred
P.O. Box 9183
Watertown, MA 02471-9183

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, see [Claim Specifications](#).

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 Tufts Medicare Preferred Members who meet eligibility criteria and are Members on the date of service.
 - Furnished by a provider eligible for payment under Medicare.
 - 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 your agreement with Tufts Medicare Preferred (if applicable).
 - Provided in the Member's *Evidence of Coverage* document.
 - Medically necessary as defined in the Medicare coverage guidelines.
- Tufts Medicare Preferred received the claim within 60 days from the date of service or the date of discharge if the Member was inpatient, or date of the primary insurance carrier's explanation of benefits (EOB).
- The services were preregistered and/or prior authorized in accordance with Tufts Medicare Preferred's preregistration and precertification procedures.
- The services were billed using the appropriate CPT codes and/or HCPCS codes.
- In the case of physician 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 HCPCS and/or CPT code.

All services rendered to Tufts Medicare Preferred Members must be reported to Tufts Medicare Preferred as claims data. Claim forms are submitted by providers for both payment and tracking purposes.

All services rendered to Tufts Medicare Preferred HMO Members must be reported to Tufts Medicare Preferred 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.

Statement of Account

The Tufts Medicare Preferred Statement of Account (SOA) is a weekly report that lists all paid, denied and pended claims. The SOA for capitated providers shows zero dollars paid, and the pay code indicates that services were prepaid under the capitation agreement. The SOA for noncapitated providers indicates the amount paid, denied or pended, with a message code indicating the claim status.

Summary of Claims in Process

Tufts Medicare Preferred 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 looks like the Statement of Account (SOA) reports, 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.

All entries on the Summary of Claims in Process appear on the SOA when adjudicated.

Electronic Remittance Advice

Upon request, Tufts Health Plan offers the HIPAA Standard 835 Health Care Claim Payment/Advice Transaction. This electronic remittance advice (ERA) includes paid and denied claims submitted via EDI or on paper forms and uses HIPAA standards reason codes.

Providers interested in receiving the ERA should contact EDI Operations:

- Via email at EDI_operations@tufts-health.com, or
- By calling 1-888-880-8699 x4042

See Tufts Health Plan's [HIPAA 835 Companion Document](#) for information about the HIPAA standard 835 transaction.

Claims Reports

Tufts Medicare Preferred sends the following reports to medical groups regarding claims for patients in their group:

- A **Weekly Referral Report** includes claims for which Tufts Medicare Preferred has not received a referral. The report gives the PCP an opportunity to authorize or deny the payment of billed services. The group has 10 business days from the date of the letter that accompanies the report to respond with a pay or deny response. The Notice of Attestation of Authorization and Denial of Payment must accompany the returned report and must include a valid reason for a denial. The form must be signed and dated by the Member's PCP, a covering provider, or the medical director. Note that a stamped signature is not appropriate. After 10 business days, any claims for which a response is not received are considered authorized.
- The biweekly **Adjusted Claims Report** includes claims that Tufts Medicare Preferred 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.

Corrected Claims

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

Electronic Submissions

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either "7" (corrected claim), "5" (late charges), or "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

Disputes (not corrected claims) must include completed [Provider Payment Dispute Form](#). Both corrected claims and disputes, however, should be mailed to the address on the form.

For a corrected **facility** claim:

- 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).

For a corrected **professional** claim:

- In Box 22 (Medicaid Resubmission Code) 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."

Filing Limit

Filing Limit Policy

Tufts Medicare Preferred follows the guidelines described in the Tufts Health Plan [Claims Submissions Policy](#). For professional or outpatient services, Tufts Medicare Preferred must receive claims within 60 days from the date of service. For inpatient or institutional services, Tufts Medicare Preferred must receive claims within 60 days from the date of hospital discharge. When a Member has multiple insurance plans, the filing limit for claims submission is 60 days from the date of the primary insurer's explanation of benefits (EOB).

Filing Limit Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 120 days of the SOA date on which the claim originally denied. Disputes received after 120 days will not be considered.

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 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 limit and any supporting documentation. Documented proof of timely submission must be submitted with any request for review and payment of a claim previously denied due to the filing limit. A completed [Provider Payment Dispute Form](#) must also be sent with the request.

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 Medicare Preferred.
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim.
- Proof that the Member or another carrier had been billed, *if the Member did not identify him/herself as a Tufts Medicare Preferred Member at the time of service.*

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

- For claims submitted through a clearinghouse, a copy of the transmission report and rejection report showing that the claim **did not reject** at the clearinghouse or at Tufts Medicare Preferred (two separate reports).
- For claims submitted directly to Tufts Medicare Preferred, the corresponding report showing that the claim **did not reject** at Tufts Health Plan.
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim.
- Proof that the Member or another carrier had been billed, *if the Member did not identify him/herself as a Tufts Medicare Preferred 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 limit adjustments should be sent to the following address:

Tufts Health Plan Medicare Preferred
Provider Payment Disputes
P.O. Box 9162
Watertown, MA 02471-9162

Provider Disputes

Providers who disagree with the reimbursement, adjudication or denial of a claim can submit a payment dispute to:

Tufts Health Plan Medicare Preferred
Provider Payment Disputes
P.O. Box 9162
Watertown, MA 02471-9162

Payment disputes must include a copy of the SOA, appropriate documentation, and a completed [Provider Payment Dispute Form](#). For more information on the dispute process, see the Tufts Health Plan [Provider Payment Dispute Policy](#).

For payment disputes involving Tufts Medicare Preferred Private-Fee-For-Service claims, see the [PFFS Terms and Conditions of Payment](#).

Note: Payment disputes cannot be submitted via Electronic Data Interchange (EDI). However, corrected claims may be submitted via EDI using the frequency code.

Coordination of Benefits

Members may have private health insurance that takes precedence over their Tufts Medicare Preferred coverage. Tufts Medicare Preferred Providers should observe the following rules to determine which plan has the primary obligation to provide benefits:

- If the patient is covered by more than one health plan at the time of service and Tufts Medicare Preferred is the secondary insurer, do not take a cost-sharing amount up front. Submit the claim to the private carrier as the primary insurer, then submit the claim with the primary insurer's explanation of benefits (EOB) to the secondary insurer (Tufts Medicare Preferred).
- If a cost-sharing amount is due, it will appear on your Statement of Account (SOA) at the time of payment, and you may then bill the patient. Whether Tufts Medicare Preferred is the primary or secondary insurer, the Member must follow plan procedures to receive benefits.
- If a claim is submitted stating that other coverage exists, the corrected claim must also be submitted. Submit the claim no more than 60 days after the EOB is received. Tufts Medicare Preferred is responsible for identifying and coordinating benefits.

For additional information, refer to the [Coordination of Benefits Policy](#) on our Web site. Questions regarding coordination of benefits may be directed to the Tufts Medicare Preferred COB Department at (617) 972-1098.

Filing Limit for Coordination of Benefits Claims

The filing limit for claims submission in the case of multiple insurance carriers is 60 days from the date of the primary insurer's explanation of benefits (EOB). The EOB from the primary insurer must be submitted with the claim when Tufts Health Plan Medicare Preferred is the secondary payer.

Coordination of Benefits Adjustments

If submitting for coordination of benefits (COB) adjustments, do not send a new claim unless one was not initially submitted. Instead, send a copy of the SOA with the primary carrier's EOB and the [Provider Payment Dispute Form](#). The original claim will be adjusted accordingly.

Subrogation

Subrogation is another 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 his insurer). In some instances, Tufts Medicare Preferred has the right to recover the value of services provided to Members for which a third party is responsible.

Tufts Medicare Preferred has outsourced subrogation recovery services to the Rawlings Company in Louisville, KY, and as a result you may receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Medicare Preferred 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 should be directed to the Tufts Medicare Preferred Provider Relations Department at 1-800-279-9022.

Note: Do not bill the Member or the Member's attorney directly even if you are requested to do so by either of them. If you choose to bill the Member or attorney directly, you do so at your own risk.

Motor Vehicle Accidents (No-Fault or PIP Coverage)

Tufts Health Plan coordinates with the Personal Injury Protection (PIP) and/or Medical Payment (Medpay) benefits on claims for services rendered as a result of a motor vehicle accident (MVA). Members should not be billed or required to pay up front for services as a result of a MVA, other than applicable cost-sharing amounts. For motor vehicle accident claims, providers should bill the motor vehicle carrier directly. The motor vehicle insurer is primary for the full PIP coverage and/or any available MedPay coverage.

After receiving the insurer's statement or check, if further payment is requested, providers must bill Tufts Medicare Preferred within the 60-day filing limit date from the date the statement or check was issued.

Note: Under your Tufts Medicare Preferred contract, once the Member's PIP and MedPay benefits are exhausted, you cannot balance bill the Member or file a lien against the Member's third party settlement or judgment. For more information, refer to the [Motor Vehicle Accident Payment Policy](#) on our Web site. For questions regarding third-party liability, contact the Rawlings Company at 502-587-1279.

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 instructions in [UB-04 Claim Form Specifications](#). 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 Form

Use the CMS-1500 form to submit a Medicare claim for non-institutional services. All providers, including internal medicine, gynecology and psychiatry, should use ICD-9-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 [CMS-1500 Claim Form Specifications](#).

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

Box	Field Name	Instructions
1	Untitled	Enter the name and payment address of the hospital/provider.
2	Untitled	Enter the address of the payee if different from the address in box #1.
3 a-b	Patient Control Number	<ul style="list-style-type: none"> • 3a: Enter the patient account number as assigned by the hospital. • 3b: Enter the medical record number.
4	Type of Bill	Enter the 3-digit code to indicate the type of bill submitted.
5	Federal Tax Number	Enter the hospital/provider's federal tax ID number.
6	Statement Covers Period	<p>Enter the beginning and ending services dates for 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.</p> <p>If the FROM and THROUGH dates differ, Tufts Medicare Preferred requires these services to be itemized by date of service (see box # 45).</p>
7	Untitled	Not Applicable
8 a-b	Patient Name	<ul style="list-style-type: none"> • 8a: Enter patient ID number • 8b: Enter the patient's last name, first name and middle initial, if any, as shown on the patient's Tufts Medicare Preferred Member identification card.
9 a-e	Patient Address	Enter the patient's mailing address from the patient record.
10	Birthdate	Enter the patient's date of birth (MMDDYY).
11	Sex	Enter M or F.
12	Admission Date	Enter the date of this admission/visit.
13	Admission Hour (HR)	Enter the time of this admission/visit.
14	Admission Type	Enter the code indicating the type of this admission/visit.
15	Admission Source (SRC)	Enter the code indicating the source of this admission/visit.
16	Discharge Hour (DHR)	Enter the time the patient was discharged.
17	Patient Discharge Status (STAT)	Enter the code to indicate the status of the patient as of the THROUGH date on this billing (box #6).
18-28	Condition Codes	Enter the code used to identify conditions relating to this bill that can affect payer processing.
29	Accident (ACDT) State	Enter the state in which an auto accident occurred, if applicable.
30	Untitled	Not applicable.
31-34	Occurrence Codes and Dates	<p>Enter the code and associated date defining a significant event relating to this bill that may affect payer processing.</p> <p>Note: Tufts Health Plan requires reporting of all accident-related occurrence codes.</p>
35-36	Occurrence Span: Codes and Dates	Enter a code and the associated dates that identify an event that relates to the payment of the claim.

Box	Field Name	Instructions
37	Untitled	Not applicable.
38	Untitled	Not applicable.
39-41	Value Codes and Amounts	Not applicable.
42	Revenue (REV) Codes	Enter the most current uniform billing revenue codes.
43	Revenue Description	Enter a narrative description of the services/procedures rendered. Use CPT-4 / HCPCS definitions whenever possible.
44	HCPCS/Rates	For outpatient services, use CPT and HCPCS Level II codes for procedures, services and supplies. 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	Enter the date the indicated service was provided.
46	Units of Service	Enter the units of service rendered per procedure.
47	Total Charges	Enter the charge amount for each reported line item.
48	Non-Covered Charges	Enter any non-covered charges for the primary payer pertaining to the revenue code.
49	Untitled	Not applicable
50 A-C	Payer Name	List all other health insurance carriers on file. If applicable, attach an EOB from other carriers.
51	Health Plan ID	List the provider number assigned by the health insurer carrier.
52	Release of Information (REL INFO)	Not applicable
53	Assignment of Benefits (ASG BEN)	Not applicable
54	Prior Payments (payer and patient)	Report all prior payment for the claim. Attach EOB from another carrier, if applicable.
55	Est. Amount Due	Not applicable
56	NPI	Enter valid NPI number of the servicing provider
57 A-C	Other Provider (PRV) ID	Not applicable
58 A-C	Insured's Name	Enter the name of the individual carrying the insurance.
59 A-C	Patient's Relationship to the Insured (P REL)	Enter the code indicating the relationship of the patient to the identified insured/subscriber
60 A-C	Insured's Unique ID	Enter the patient's Tufts Health Plan Medicare Preferred identification number, including the suffix, as shown on the patient's Tufts Medicare Preferred Member identification card
61 A-C	Group Name	Enter the name of the group or plan through which the insurance is provided to the insured
62	Insurance Group Number	Enter the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered

Box	Field Name	Instructions
63 A-C	Treatment Authorization Code	Enter the Tufts Medicare Preferred referral/authorization number for out-patient surgical day care services
64	Document Control Number	Not applicable
65	Employer Name	Enter the name of the employer for the individual identified in box # 58, if applicable
66	DX Version Qualifier	Not applicable
67 a-q	Principal Diagnosis Code	Enter the most current ICD-9-CM code describing the principal diagnosis chiefly responsible for causing this admission/visit. The code must be to the 4 th or 5 th digit specification, if applicable. If the diagnosis is accident-related, then an occurrence code and accident date are required. The POA indicator is the 8 th digit of the Field Locator and the 8 th digit of each of the Secondary Diagnosis fields, a-q. Report the applicable POA indicator (Y, N, U or W) for the principal and any secondary diagnoses and include this as the 8 th digit. Leave this field blank if the diagnosis is exempt from POA reporting.
68	Other Diagnosis Codes	Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently. The code must be to the 4 th or 5 th digit specification, if applicable.
69	Admit DX	Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.
70	Patient Reason DX	Optional
71	PPS (Prospective Payment System) Code	Optional
72	ECI (External Cause of Injury) Code	Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect.
73	Untitled	Not applicable
74 a-e	Principal Procedure Code (code and date)	Enter the most current ICD-9-CM code to the 4 th digit specification, if applicable, to describe the principal procedure performed for the service billed. Also enter the date the procedure was performed. The date must be entered as month and day (MMDD).
75	Untitled	Not applicable
76	Attending Physician	Enter the ordering physician's NPI, physician's last name, first name and middle initial.
77	Operating	Enter the name and NPI number of the physician who performed the principal procedure, if applicable.
78-79	Other Provider Types	Optional
80	Remarks	Not applicable
81 a-d	ICC	Optional

Figure 2: CMS-1500 Claim Form Specifications

Box	Field Name	Instructions
1	Type of Insurance Coverage	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	Enter the patient's current identification number exactly as it appears on the Member's Tufts Medicare Preferred ID card, including the alpha prefix and number suffix. Inaccurate or incomplete ID numbers will cause a delay in processing the claim and can result in a denial.
2	Patient's Name	Enter patient's last name, first name and middle initial, if any, as shown on the patient's Tufts Medicare Preferred ID card.
3	Patient's Birth Date and Sex	Enter patient's date of birth and sex.
4	Insured's Name	If insured and patient are the same person, enter <i>SAME</i> . If the insured and patient are not the same person, enter the name of the insured (last name, first name and middle initial).
5	Patient's Address	Enter the patient's permanent mailing address and telephone number: <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	Check the appropriate box for the patient's relationship to the insured (self, spouse, child, other).
7	Insured's Address	If insured's address is the same as patient's address, enter <i>SAME</i> . If the insured's address is different than the patient's address, enter insured's permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.
8	Patient Status	Check the appropriate box for the patient's marital status and whether employed or a student.
9	Other Insured's Name	If this insured is the same as the person in box # 4, enter <i>SAME</i> . If this 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	If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Other Insured's Date of Birth and Sex	Enter the other insured's date of birth and sex.
9c	Employer's Name or School Name	Enter the other insured's employer's name or school name.
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan name or program name. Attach the other insurer's EOB to the claim.
10a-c	Is Patient's Condition Related To:	For each category (Employment, Auto Accident, Other Accident), check either <i>YES</i> or <i>NO</i> . When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection benefits have been exhausted. Enter the state postal code where the auto accident occurred.
10d	Reserved for Local Use	Use this field to indicate that other identifying insurance information is attached to the claim.

Box	Field Name	Instructions
11	Insured's Policy Group or FECA Number	If the insured has other insurance, indicate the insured's policy or group number.
11a	Insured's Date of Birth and Sex	Enter insured's date of birth and sex if different from the information in box # 3.
11b	Employer's Name or School Name	Enter employer's name or school name, if applicable. If the insured is retired, enter the retirement date, preceded by the word <i>RETIRED</i> . This field is used to determine if Tufts Medicare Preferred is the primary or secondary payor.
11c	Insurance Plan Name or Program Name	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?	Check either <i>YES</i> or <i>NO</i> to indicate if there is another primary health benefit plan. For example, a patient may be covered under insurance held by a spouse, parent or other person
12	Patient's or Authorized Person's Signature	If the signature is not on file, the patient or authorized representative must sign and date this box. If the signature is on file, enter <i>Signature on File</i> . If an authorized representative signs, indicate this person's relationship to the patient.
13	Insured's or Authorized Person's Signature	If the signature is not on file, the insured or authorized representative must sign this block to authorize payment of benefits to the participating provider or supplier. If the signature is on file, enter <i>Signature on File</i> .
14	Date of Current Illness, Injury, or Pregnancy	Enter the date of the current illness, injury or pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	If the patient has had the same or a similar illness, enter the first date.
16	Dates Patient Unable to Work In Current Occupation	If the patient is unable to work in current occupation, enter the dates. An entry in this box could indicate employment-related insurance coverage.
17	Name of Referring Provider or Other Source	Enter the name of the referring/ordering provider or other source if the patient: <ul style="list-style-type: none"> • Was referred to the performing provider for consultation or treatment • Was referred to an entity, such as clinical laboratory, for a service • Obtained a physician's order for an item or service from an entity, such as a DME supplier
17a-b	ID Number of Referring Physician	Enter the NPI-assigned physician identification number of the referring or ordering physician. Referring physician information is required if another physician referred the patient to the performing physician for consultation or treatment. Ordering physician information is required if a physician ordered the diagnostic services, test or equipment.
18	Hospitalization Dates Related to Current Services	Enter the admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization.

Box	Field Name	Instructions
19	Reserved for Local Use	Enter the date the patient last saw the referring and/or ordering physician for a claim billed by an independent physical therapist or podiatrist.
20	Outside Lab	Check either <i>YES</i> or <i>NO</i> to indicate if laboratory work was performed outside the physician's office.
21	Diagnosis or Nature of Illness or Injury	Enter the diagnosis/condition of the patient as indicated by the ICD-9-CM code number. Enter up to four codes in priority order (primary, secondary condition).
22	Medicaid Resubmission Code	If this is a Medicaid resubmission, enter the code and original reference number.
23	Prior Authorization Number	If applicable, enter Tufts Health Plan Medicare Preferred's preregistration or referral number.
24a	Date(s) of Service	Enter the dates for <u>each</u> procedure in MMDDYY format, omitting any punctuation. Itemize each date of service. Do not use a date range.
24b	Place of Service	Enter the appropriate place of service code.
24c	EMG	Check this item if the service was rendered in a hospital or emergency room.
24d	Procedures, Services, or Supplies	Enter valid CPT/HCPCS procedure codes and any modifiers.
24e	Diagnosis Pointer	Enter up to four ICD-9-CM diagnosis codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. If multiple services were performed, enter the diagnosis codes warranting each service.
24f	\$ Charges	Enter the charge for each listed service.
24g	Days or Units	Enter the days or units of service rendered for the procedures reported in box # 24d.
24h	EPSDT Family Plan	Check this box if early and periodic screening, diagnosis and treatment, or family planning services were used.
24i	ID Qual	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 #	Enter the rendering provider's NPI number if the rendering provider is not the billing provider.
25	Federal Tax ID Number	Enter the physician/supplier's federal tax ID, employer ID number, or Social Security number.
26	Patient's Account Number	Enter the patient's account number assigned by the physician's/supplier's accounting system. This is an optional field to enhance patient identification by the physician or supplier.
27	Accept Assignment?	Check <i>YES</i> or <i>NO</i> to indicate whether the physician accepts assignment for the claim. By accepting assignment, the physician agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter.

Box	Field Name	Instructions
28	Total Charge	Enter the total charges for the services (i.e., the total of all charges in box # 24f).
29	Amount Paid	Enter the total amount paid by any other carrier/entity for the submitted charges in box # 28. Attach supporting documentation of any payments (such as Explanation of Benefits, Statement of Account, canceled check copy).
30	Balance Due	Enter the balance due (the amount in box # 28 minus the amount in box # 29).
31	Signature of Physician or Supplier Including Degrees or Credentials	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 <i>Signature on File</i> .
32, 32a-b	Service Facility Location Information	If other than home or office, enter the name and address of the facility where services were rendered to the patient. Enter the NPI number for the facility Enter other ID number, if applicable
33, 33a	Billing Provider Info & Ph #	Enter the name and payment address of the entity receiving payment. This must match the Tax ID and name on file with the Internal Revenue Service. Enter the NPI number for the entity receiving payment.