

Avoiding Common Claim Submission Errors

Please ensure claims contain:

- 1. Correct member name** – the patient name on the claim must match the patient name as listed on the member ID card.
- 2. Correct date of birth.**
- 3. Member ID number, including:**
 - member suffix: member number on claim must contain the correct two-digit suffix that identifies the patient
 - complete member ID number
 - no asterisk or spaces
- 4. Providers offering multiple services and multiple provider setups**, must bill the appropriate NPI/Tax ID on the claim to eliminate assignment logic delays.
- 5. Rendering/Individual NPI** should be listed in box **24J**, "Rendering Provider ID #," in the bottom unshaded portion of the box labeled "NPI."
- 6. Taxonomy code** should be listed in the top shaded portion of box **24J**. Claims submitted without the correct taxonomy code will be rejected or denied.
- 7. Billing/Group NPI** should be listed in box 33a, "Billing Provider Info & PH #."
- 8. Services requiring pre-authorization can be found on sentarahealthplans.com/providers.** If unsure, contact provider services at **757-552-7474** or **1-800-229-8822**.
- 9. Coordination of Benefits, Sentara Health Plans as secondary carrier.** Claims must be submitted with Explanations of Benefits (EOBs) attached and the identical information included on the original claim.
 - Providers may not bill one insurance carrier for one charge amount and Sentara Health Plans for a different charge amount.
 - If a claim is filed for a member whose primary insurance is not Sentara Health Plans, the provider must submit an EOB for the claims within 18 months of the date of service.
- 10. Non-Participating Providers** - After the Coordination of Care period, providers must secure a fully executed contract to participate with Sentara Health Plans. For details on joining the network, visit: **sentarahealthplans.com/providers**.

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Please note: Timely filing deadline on all claims is 365 days from the date of service. This applies to initial submissions, corrections, reconsiderations, and appeals.

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

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA (EMPLOYER) ☐ OTHER ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (SMP)

15. OTHER DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB?

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-E to service line below (SHE))

22. ICD-9-CM CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. Repeat for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

34. TAXONOMY CODE

35. INDIVIDUAL NPI, Box 24J

36. GROUP NPI, Box 33a

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