# **Claims Submission Process**

To access our portal, visit BuckeyeHealthPlan.com/providers.html





#### Claims

To access Claim information from inside the patient record,

1. Select Claims on the left.

Note: The Claims tab of the patient record allows you to view any recent claims for the patient, and also create a new claim. If the patient has any recent claims, they display on this tab.

The following screen appears:

No. of Concession, Name	_		Eligibility	L. Patients	Authorizations	Claims	Messaging		
Jewing Patients For :									Find Patient
Back to Patient List									
Överview	CLAM	REFIACCT	DOS	PAYMENT	PAYMENT	SERVICIN	6	BILLED/	
Cost Sharing	NO. †	NO/1	RANGE 1	DATE :	DATE :	PROVIDER	R1	PAID 1	STATUS :
Assessments	003104034099	8	01/28/2015 - 01/28/2015	02/09/2015	01/31/2015			\$230.007 \$53.44	PAID
Health Record	One item found. Pa	ge 1/1 1							
Care Plan	Create a New	Claim							
Authorizations									
Referrals									
Coordination of Benefits									
Glaims									

2. Click the Green Create a Claim button to begin a new claim for this patient.

	Cinge May	L. Patients	2 Authorizations	Claims	Wrstaging	
Viewing Clasms For :	• •				Upload EDI	Create Claim
Choose Claim for						
Choose a Claim Type						
CMS 1500			CI	NS U	B-04	
Professional Claim +		1	Inst	tutional	Claim +	
Terms & Cond	ditions Privacy Policy Cop	yright © 201	5, Centene Corpo	ration		

#### 1. Select **Professional Claim** by clicking the green button.

The following screen appears.

	Tour Progres				
THIS SECTION General Info Information	about the dates of the claim.				
					Next +
equired field					
Patient's Account Number*	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				26
Patient's Account Number* Date of current illness, injury, Pregnancy (LMP)	Select Type	•   [ MM/DD/YY	YY		26

- 2. In the General Info section, populate the Patient's Account Number, and other information related to the patient's condition by typing into the appropriate fields.
- 3. Click Next.

#### Adding Diagnosis codes and coordination of benefits

- 4. Add the Diagnosis Codes for the patient in Box 21
- 5. Click the Add button to save the appropriate Diagnoses code for the patient

e information.
Next +
note that for the claim statement dates entered, ID-9 codes only are accepted.
diagnosis code and click on Add button)
Hamave X
Next +

6. Click the **Coordination of Benefits Button** (if applicable) or the **Next** button.

#### Adding Coordination of Benefits

7. Click Add Coordination of Benefits to include any payments made by another insurance carrier (if applicable)

Couries 7	CERN Community	5	
Garren	Abe Contra Contractor		
Policy Nur	ber*	c	

- 8. Enter the Carrier Type and the Policy Number
- 9. Click Next

#### Primary Insurance

Amount Allowed*	100.00	
Deductible	XXXX.XX	
Сорау	XXXX.XX	
Co-Insurance	XXXX.XX	
Amount Paid	100.00	
ce Line Denial Reaso denied category,enter amo	ns unt and click "Add Denied Reason" to add a denied amount to your claim.	
Denied Category	Select	
Denied Category Denied Amount	Select	
Denied Category Denied Amount	Select  XXXX.XX  Add Denied Reason	
Denied Category	Select  XXXX XX  Add Denied Reason  \$ 158.39 Non-Covered Service	Remove X

- 10. Enter the pertinent information from the primary insurance
  11. Select Save/Update
- 12. Click Next

#### Adding Service Lines to the claim

The following screen appears:

rofessional Claim for	Your Progress	$\rangle \rangle$
THIS SECTION Service Lines	Enter maximum of 50 service lines.	
+ Back		Next +
Total:\$100.00	* Required field Delete	Save / Update
+ New Service Line	Now Viewing 992147 \$100.00	
PROCEDURE / CHARGES	Dates of Service* From 03/03/2014 To 03/03/2014	24.8
99214/\$100.00		
	Place of Service* 11 PROVIDERS OFFICE •	24.6
	Procedure Code* 99214	24.6
	Modifiers XX Add Please enter the modifier and click the Add butto	n.
	Diagnosis Code(s)* 🛛 473 - CHRONIC SINUSITIS	24.8
	Charges* 100.00	241
	Days / Units* 1	24.0
	Family Planning Yes No EPSDT Select.	24h
	NDC NDC	NDC

13. In the Service Lines section, add your service line information.

\*\*\*Note: When entering charges for the service billed, include the decimal point to ensure the data is populated accurately. For example, 99.00 convert to \$99.00.

- 14. To add additional service lines, click the **Save/Update** button and then click the **New Service Line** button. Enter up to 99 service lines.
- 15. Click Next

# Adding Provider Information to the claim

and the second							-
wing Claims For 2			•		1	Upload EDI	Create Claim
			×	Deserves			
Protessional Graim for			-11	our Progress	1_1	/ /	/ / /
Providers Provide	rts on this claim.						
+ Back							Next +
* Required Seld							
Referring Provider							
NPI							17.
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	ovidur						Contraction of the second
Last Name or Organizational Name	First Na	me					
Last Name Find P	evider First I	lame .					
API Medicaid Provider 2000000000 200000000000000000000000000	# Tax ID First Name	ed Provider					24j
Last Name	First Name	Over 7					
Billing Provider							
fax ID							33
	A 1001		1121020-00120-00200				
Vame*	NPI		Medicaid Provider				
Name* Last Name	300000000		X00000000				
Name* Last Name 5ddress* City*	5000000000 State*	Zip*	Medicald Provider				
Name* Last Name  kddress* City*  X00000000X  X0000000X	State*	Zip*	Nedicaid Provider				
Name* Last Name Address* City* X0000000000 X0000000000000000000000000	Sale* Select.	Zip*	Medicaid Provider				
Name* Last Name kddress* City* XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	State* State* Select.	Zip* XXXXXX • As Billing Prov	Medicaid Previder				12
Name* Last Name Address* City* XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	State* Select. Select. NFT XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	20p* XXXXXX o As Binny Prov	Medicaid Provider				22
Name* Last Name  Address* City* X000000000  X00000000  City* X000000000  City* X00000000  City* X00000000  City* X00000000  City* X00000000  City* X00000000  City* X00000000  City* X0000000  City* X00000000  City* X0000000  City* X0000000  City* X00000000  City* X0000000  City* X0000000  City* X0000  City* X0000  City* X0000  City* X0000  City* X000  City* X00  City* X0 X00  City* X0 X00  City* X0	Nari Socoocococococococococococococococococo	Zip* XXXXXX a As Billing Prov	Medicaid Previder		Žip		22
Name* Last Name Address* City* X000000000 X00000000 Xame Last Name Address X000000000X	Nan           300000000           State*           Select.           cation           Same           NPI           300000000x           City           3000000000x	Zip* XXXXXX > As Balang Prov	Medicaid Previder		Ζφ • 20000		22
Name* Last Name Address* City* X00000000X X0000000X Service Facility Lo Name Last Name X00000000X	Nan Soboodooox State* Select. Cation Sam NFI Soboodooox City Soboodooox	Zip* XXXXXX > As Being Pro	Medicaid Previder 200000000 vider State State Select.		Zp • XXXXX		22
Vame* Last Name  Address* City* XXXXXXXXXX Service Facility Lo  Same Last Name Vddress XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Nam           1000000000           State*           Select.           cation           NFI           100000000x           City           1000000000x	Zip* XXXXXX 6 As Billing Pro	Medicaid Provider		2p • 20000		22.

- 16. Enter referring and billing provider information17. Enter Service Facility Location18. Click Next

## Adding Attachments to a claim.

The following screen appears:

	Elgébility	L. Z Patients Authorizations	Claims Messaging	
hewing Claims For :	•	•	1 Upload E	Di Create Claim
Professional Claim for	Your Progress	$\rightarrow$ $\rightarrow$ $\rightarrow$		
THIS SECTION Attachments Ad	d attachments to the claim (5MB limit)		Supported types are	jpg, tif, pdf and tiff
ttachments				
ie*	Attachment Type*			
Browse	Select Type		Albach	
Itachment Name		Туре		
		Consent F	9em	Reduce
+ Back	If there are no	attachments, click Ne	ext.	Next +

19. In the Attachments section you can Browse and Attach any documents to the claim as desired.

Note: If you have no attachments, skip this section

20. Click Next

## The Review Section of the claim

	ns For :			•	·				n	Upload EDI	Create C
									_		
rofessi	onal Claim	for			Your Progress		<u> </u>	$\geq$			
			unur da	im and subm							
You are	e correcting a	claim for	your cla	im and subm							
Almo	ost do	ne!									Submit-
ou can go	back to review	your claim or	submit no	w.							
Clai	im Id:										
Membe	r Record Num	er:									
Patient	's Account Num	iber:									
Ger	neral In	fo									
Hospita	lized From:										
Hospita	lized To: Lab?: No										
Outside	Lab Amount										
CLIA N	umber:	mper.									
Diagno	sis Codes										
95909	- INJURY FAC	CESNECK OTH	ER&UNS	PECIFIED							
7231 -	- CERVICALG	A									
7245 -	- UNSPECIFIE	D BACKACHE									
Ser	vice Li	nes									
Line	From	То	Place	Proc	Diagnosis	Amount	Days/Units	Family Plan	EPSDT	NDC Su	pplemental info
Line 1	03/19/2015	To 03/19/2015	Place 41	Proc A0429 (SH)	Diagnosis 95909,7231,7245	Amount \$815.67	Days/Units	Family Plan	EPSDT	NDC Su	pplemental Info
Line 1 2	From 03/19/2015 03/19/2015	To 03/19/2015 03/19/2015	Place 41 41	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245	Amount \$815.67 \$175.88	Days Units 1 12	Family Plan No No	EPSDT	NDC Su	pplemental info
Line 1 2 Pro	03/19/2015 03/19/2015 03/19/2015	To 03/19/2015 03/19/2015	Place 41 41	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245	Amount \$815.67 \$175.88	Days/Units 1 12	Family Plan No No	EPSDT	NDC Su	ppiermental Info
Line 1 2 Provid	03/19/2015 03/19/2015 03/19/2015 OVICIES der Type	To 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days/Units 1 12 Me	Family Plan No No dicaid #	EPSDT	NDC Su	pplemental Info
Line 1 2 Provi Refer	o3/19/2015 03/19/2015 03/19/2015 oviders der Type ringProvider	To 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days:Units 1 12 Me	Family Plan No No	EPSDT Address	NDC Su	pplemental Info
Line 1 2 Provie Reference Render	o3/19/2015 03/19/2015 oviders der Type ringProvider eringProvider	To 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days:Units 1 12 Me	Family Plan No No dicaid #	EPSDT Address	NDC Su	pplemental Info
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Line 1 2 Provid Refer Rende Billing Service	o3/19/2015 03/19/2015 oviders der Type ringProvider eringProvider iProvider er Facility Loca	To 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days:Units 1 12 Me	Family Plan No No dicaid #	EPSDT	NDC Su	pplemental Info
Line 1 2 Provid Refer Rende Billing Servic	o3/19/2015 03/19/2015 oviders der Type ringProvider eringProvider iProvider	To 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days.Units 1 12 Me	Family Plan No No	EPSDT	NDC Su	pplemental Info
Line 1 2 Provie Refer Rende Billing Servic Atta	oginia construction of the second of the sec	To 03/19/2015 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days.Units 1 12 Me	Family Plan No No dicaid #	EPSDT	NDC Su	pplemental Info
Line 1 2 Provid Refer Rendel Billing Servic Atta	oli 19/2015 03/19/2015 oviders der Type ringProvider eringProvider iProvider ce Facility Loca achmer	To 03/19/2015 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245 Tax ID	Amount \$815.67 \$175.88 NPI	Days.Units 1 12 Me	Family Plan No No dicaid #	EPSDT Address	NDC Su	pplemental Info
Line 1 2 Provid Refer Rendd Billing Servic Atta	o3/19/2015 03/19/2015 oviders der Type ringProvider eringProvider iProvider ce Facility Loca achmer	To 03/19/2015 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245	Amount \$815.67 \$175.88 NPI	Days.Units 1 12 Me	Family Plan No No dicaid #	EPSDT Address	NDC Su	pplemental Info
Line 1 2 Provid Refer Rende Billing Servic Atta	oginiaria de la composición de	To 03/19/2015 03/19/2015 03/19/2015	Place 41 41 Name	Proc A0429 (SH) A0425 (SH)	Diagnosis 95909,7231,7245 95909,7231,7245	Amount \$815.67 \$175.88 NPI	Days.Units 1 12 Me	Family Plan No No dicaid #	EPSDT Address	NDC Su	pplemental Info

- 21. In the Review section, you can review the claim once again22. Click Submit.

# Creating an Institutional Claims

Select the CMS UB-04 Institutional Claim button from the member record

1000		Cilgiti Cilgiti	itity Patienta	Matherizations	Claims	Messaging	-
Vewing Claims For :	•	•	90			Upload EDI	Create Claim
Choose Claim for							
Choose a Claim Type							
CI	MS 1500			C	NS U	B-04	
Protes	isional Claim +			Instr	tutional	Claim +	
	Terms & Conditions	Privacy Policy	Copyright © 20	15. Centene Corpo	ration		

	Tour Progress	
THIS SECTION General Enter Information fo	r the Admission and Condition Codes	
Required Seld		
Patient Control #*	1234	3.8
Medical Record #	1222	36
Type Of Bill*	121 •	4
Statement Dates*	From 01/01/2015 To 01/30/2015	6.
Prior Payments		54
Prior Authorization Number		63.
dmission		
Time*	Date 01/01/2015 Hour 01 •	12-13
Time* Type*	Date         01/01/2015         Hour         01         •           1 - Emergent         •	12-13
Time* Type* Source*	Date     01/01/2015     Hour     01       1 - Emergent     •       5 - Transfer From A Skilled Nursing Facility     •	12-13
Time* Type* Source* Discharge	Date     01/01/2015     Hour     01       1 - Emergent     •       5 - Transfer From A Skilled Nursing Facility     •	12-13
Time* Type* Source* Discharge Status*	Date       01/01/2015       Hour       01         1 - Emergent       •         5 - Transfer From A Skilled Nursing Facility       •         03 - Discharged/transferred to a skilled nursing facility (SNF).       •	12-13
Time* Type* Source* Discharge Status* Hour	Date       01/01/2015       Hour       01         1 - Emergent       •         5 - Transfer From A Skilled Nursing Facility       •         03 - Discharged/transferred to a skilled nursing facility (SNF).       •         14       •	12-13 14 15 17. 16.
Time* Type* Source* Discharge Status* Hour	Date       01/01/2015       Hour       01         1 - Emergent       •         5 - Transfer From A Skilled Nursing Facility       •         03 - Discharged/transferred to a skilled nursing facility (SNF).       •         14       •	12-13 14 15 15 17. 16. Next →

- 1. In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form.
- 2. Click Next

Note: Hovering over the Claim Field Tabs to the right of the screen will help determine what field on the UB-04 form from which to obtain the information.

Institutional Cla	aim for	Your Progress	$\rightarrow$	$\rangle \rangle$	$\rightarrow$	$\rightarrow$	
Provide	er Details Basic in	formation about the patient's	status and condition.				
Required field							
Billing Provid	der						
	NPP		Search				56
	Taxonomy						57
	Selected Provider						
Pay-to Provid	der Samo Au Billing Provid	Ser					
(P)*	Taxonomy	IRS/Tax ID Number*	Pay-To Name*				2
Address*	City*	State*	Ziø*				
Attending Pr	ovider						
NPI	Taxonomy	First Name	LastNa	me		-	76
RS/Tax ID Number							

## Continued:

First Name	Last Name	Orga	nization Name	
Operating Provid	ler			
NPI	Taxonomy	FirstName	Last Name	73
000000000000000000000000000000000000000	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	3000000000	
RS/Tax ID Number				
PLOCEBA ID INVITIDES.				
occoccoccoccoccoccoccoccoccoccoccoccocc	(Physician) Provid	er First Name	Last Name	
Dther Operating	(Physician) Provid	er First Name	Last Name	
NONCONCON Other Operating NPI	(Physician) Provid	First Name	Last Name X000000000	
NPI XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	(Physician) Provid	First Name X000000000	Last Name 2000000000	
NPI SOCIODOCOCOCION RS/Tax ID Number SOCIODOCOCION	(Physician) Provid	First Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Last Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
Conter Operating	(Physician) Provid	First Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Last Name X000000000	
Dither Operating	(Physician) Provid	First Name X0000000000 First Name	Last Name 2000000000	] 7
Conceptions	(Physician) Provid Taxenomy 2000000000000000000000000000000000000	er First Name X000000000 First Name X0000000000	Last Name DOOOOOOOCC	7
ADDODODODOX Other Operating API ADDODODODODOX RS/Tax ID Number ADDODODODODOX ADDODODODODOX ADDODODODODOX RS/Tax ID Number	(Physician) Provid	er First Name X000000000 First Name X0000000000	Last Name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	

- 3. In the Provider Details section, enter the billing and other provider information in the appropriate fields.
- 4. Click Next

Non-Covered : \$0.00	* Required field		Delete	Save / Update
+ New Service Line	Now Viewing 120	/ \$30,000.00		
ROCEDURE / CHARGES	Revenue Code*	120 Lookup		42.
0 / \$30,000.00	_			
	HCPCS / Rate / HIPPS Code			44.
	NDC			Guid
	Modifiers	XX Add	Please enter the modifier and click the Add button.	
	Service Date*	01/01/2015		45.
	Service Units*	30		46.
	Charge Amount*	30000		47.
	Non-Charge Amount	XXXXX XX		48.
			Delete	Save / Updat

- 5. In the Service Lines section, enter the information about the services provided.
- 6. Click Save/Update, and to add a new service line
- 7. Click the **+ New Service Line** button on the left to add additional service lines. Note: You can enter up to 99 service lines. When all necessary service lines have been entered and saved
- 8. Click the **Next** button.

ewing Claims For :	• • •	Upload EDI
Institutional Claim for	Your Progress	$\rightarrow$ $\rightarrow$ $\rightarrow$ $\rightarrow$
Additional Insurance	C Enter additional insurance details.	
You may sl	ip this section if there is no additional in	Isurance, Next +
Primary Insurance		
Notice: If the Member has more than one	nimary insurance (Medicald would be the 3rd payer), the	e claim cannot be submitted through the Web.
Carrier Type	Select.	
Policy Number		
Amount Allowed	XXXXXXX	
Deductible	XXXXXXX	
Сорау	XXXXXX	
Co-Insurance	XXXXXXX	
Amount Paid	XXXXXXX	
Denial Reasons	Select	Add Denied Reason
+ Back		Next +

- 9. In the Additional Insurance section, enter any additional insurance details as needed. If there is no additional insurance, you may skip this section. 10. Click **Next**.

nstitutional Claim for	Your Progress	
THIS SECTION Diagnosis Codes	nter all relevant diagnosis codes.	
Required field		
ICD Version Indicator*	ICD 9 Please note that for the claim state valid ICD-9 codes only are accepted.	ment dates entered, ed.
Principal Diagnosis Code*	07999 POA Indicator Select. •	67
Diagnosis Codes (67A-Q)	XXXX e.g. 140! POA Indicator Select.	67.8-4
	462-ACUTE PHARYNGITIS	Remove X
Patient Reason for Visit	XXXX e.g. 140! Add	70
External Cause of Injury Code (ECI)	XXXX e.g. 140!	72.
Prospective Payment Code		71.
Condition Codes	XX.e.g. Di Add	18-28
Occurrence Codes and Span Codes	XX e.g. Df From MM/DD/YYYY To MM/DD/YYYY Add	31-36
	11-OCCURRANCE CODE 10/17/2014	Remove X
Value Code	XX Amount XX.XX Aisd	39-41
Procedure Codes	XXXX e.g. 140! Procedure Date MM//DD/YYYY Add	74
+ Back		Next →

- In the Diagnosis Codes section, enter all relevant diagnosis information.
   Click Next.

		Cligibility	L. Patients	Autho	<b>V</b> vizations	Claims	Messaj	i ing	
ewing Claims For :	•	• 60					<b>n</b> Up	load EDI	Create Claim
Institutional Claim for		Your Progress	$\boldsymbol{\Sigma}$	Σ	>	Σ	$\boldsymbol{\Sigma}$	>	
Attachments	Add attachments to the claim	(5MB limit).			S	upported	types ar	e .jpgt	r, .pdf and .tiff
Attachments									
File*	Attachment Type*								
Choose File No file chosen	Select Type	•				Attac	n		
There are no attached files									
+ Back	ift	here are no attac	hments,	click N	ext.				Next +

In the Attachments section, Choose File and Attach any relevant file to the claim.
 Click Next

- 15. Review the claim
- 16. Click Submit

national faciality			Eleption ty	10000		Clams	Messaging .	40000
g Claims For :	•		• •••				👔 Upload EDI	Create Ci
titutional Claim for L	AS I I I I I I I I I I I I I I I I I I I	Your Pro	- grave	$\sum$	$\rightarrow$	$\rightarrow$	$\rangle$	
HIS SECTION:	Submit and	mademouser citri	n hafana sui	million				
terrew and	Oublint Pese	renew your clair	n betore su	omlang.				
Imost don can go back to review you	e! In claim or submit now.							Salest.
Claim ID: 501	1645799							
General Info								
Patient Control #:								
Type Of Ril: 137								
Statement From Date: 1 Statement To Date:								
Prior Payments: Prior Authorization Numbe	r.							
Admission Date: 10/17/201 Admission Hear: 00	14							
Admission Type: 1								
Discharge Status:01								
Discharge Hour. 00								
Provider Det	alls							
Provider					Address			
Type NPI	Taxonomy Name	Ta	x ID A	ddreas (1)	(2)	City	State Zip	
Provider Type	NPI	Таконоту	First Nar	me Lo	stNone	IRS/Tex ID	Num O	rganization
Provider Type Attending Provider	NPI 1256422341	Таконопу	First Nar JOHN	me Lo CE	st None RiEN	IRS/Tex ID	Num O	rgasilation
Provider Type Atlanding Provider Rendering Provider	NPI 1255422341	Таколоту	First Nar JOHN	ne Lo CE	st Nome SRIEN	IRS/Tex ID	Num O	rgasilation
Provider Type Atlanding Provider Rendering Provider Operating Provider	NPI 1255422341	Таконотку	First Nar JCHN	ne La CE	st Nome RiEN	IRS/Tex ID	Num O	rganka5on
Provider Type Atlanding Provider Rendering Provider Operating Provider Other Operating Provider	NPI 1255422341	Taxonomy	First Nar JOHN	we La CE	st Name RJEN	IRS7ex ID	Num O	rganization
Provider Type Atlanding Provider Rendering Provider Operating Provider Other Operating Provider	NPI 1255422341	Таконоту	First Nar JCHN	ne La Ce	st Norre RiEN	IRS/Tex ID	Num O	rganization
Provider Type Atlanding Provider Rendering Provider Operating Provider Other Operating Provider Other Provider	NPI 1255422341	Таколоту	First Nar JOHN	ne La CE	st Name RJEN	IR STax ID	Nurs O	rganization
Provider Type Atlanding Provider Rendering Provider Operating Provider Other Operating Provider Other Provider Service Line	NPI 1255422341	Taxonomy	First Nar JOHN	ne La CE	st Norre RiEN	IRS/Tax ID	Nure O	rganization
Provider Type Atlanding Provider Rendering Provider Operating Provider Other Operating Provider Other Provider Service Line Line Revenue Code	NPI 1255422341 7 S HCPC \$RateMIPPS	Taxonomy Modifiers	First Nam JOHN NDC DV	me La CE	st Nome RUEN Units Ch	IRS/Tex ID	Num O	rgasitation rge Amount
Provider Type Attanding Provider Attanding Provider Operating Provider Other Operating Provider Other Provider Service Line Line Revenue Code 1 251	NPI 1255422341 7 S HCPC SRate HIPPS	Taxonomy Modifiers	First Nar JOHN NDC Du	me La CE ste 1/17/2014	st Name RIEN Units CP 1 63	IRS/Tax ID	Num O	rgasitation rge Amount
Provider Type Atlanding Provider Atlanding Provider Operating Provider Other Operating Provider Other Operating Provider Other Devider Service Line Line Revenue Code 1 2 251	NPI 1255422341 7 S HCPC SIRate HIPP S	Taxonomy Modifiers	First Nar JCHN NDC Dr 10	ne Lo Ce ste 1/7/2014	st Name SRIEN Units CP 1 83 1 \$2	IRS/Tex ID write amount 25.00	Num O	rgasilation
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