



November 2015

ICD Indicator Required on Paper Claim Forms

With the October 1, 2015 implementation of ICD-10, it may be appropriate to report either ICD-9 or ICD-10 codes, depending upon the dates of service.

Paper claim forms have an ICD Indicator that identifies the ICD code set being reported on the claim.

UniCare is requiring the ICD Indicator field be populated on paper claim forms.

Claims with this field not populated will be rejected.

UB-04 form (also known as the CMS-1450 form) – see sample form

The ICD Indicator is Field 66.
(also known as the *Diagnosis and Procedure Code Qualifier*)

Enter the qualifier code that denotes the version of the ICD code set being reported on the claim.

- | | |
|------------------|---|
| <u>Indicator</u> | <u>Code Set</u> |
| 9 | ICD-9 diagnosis codes and/or procedure codes |
| 0 | ICD-10 diagnosis codes and/or procedure codes |

The image shows a full UB-04 form with field 66 highlighted in a red box. The form includes sections for patient information, admission details, procedure codes, and charges. Field 66 is located in the top left section of the procedure code area.

A close-up view of field 66 on the UB-04 form. A yellow arrow points to the field, which contains a grid of letters: A, B, C, D in the top row and I, J, K, L, M in the bottom row. The field is labeled '66 DX' and '67'.

CMS 1500 form version 02/12 (REMINDER: We only accept the 02/12 form version)

The ICD Indicator is Box 21.

Enter the applicable ICD indicator according to the following:

Indicator	Code Set
9	ICD-9 diagnosis codes
0	ICD-10 diagnosis codes

Enter the indicator as a single digit between the vertical, dotted lines.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below. **ICD Ind.** 9

A. _____	B. _____	C. _____	D. _____
E. _____	F. _____	G. _____	H. _____
I. _____	J. _____	K. _____	L. _____

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER

1									
2									
3									
4									
5									
6									

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) 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.) SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

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

1. PROVIDER: MEDICAR, TRICARE, GROUP, HEALTH PLAN, SELF, OTHER, OTHER (Specify)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTHDATE (MM DD YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. INSURED'S BIRTHDATE (MM DD YY) SEX 6. INSURED'S POLICY GROUP OR PLAN NUMBER

7. PATIENT'S ADDRESS (Inc. Street) 8. PATIENT'S RELATIONSHIP TO INSURED 9. INSURED'S ADDRESS (Inc. Street) 10. INSURED'S POLICY GROUP OR PLAN NUMBER

11. ZIP CODE TELEPHONE (Include Area Code) 12. INSURED'S POLICY GROUP OR PLAN NUMBER 13. INSURED'S POLICY GROUP OR PLAN NUMBER

14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 15. IS PATIENT'S CONDITION RELATED TO: 16. INSURED'S POLICY GROUP OR PLAN NUMBER

17. OTHER INSURED'S POLICY OR GROUP NUMBER 18. EMPLOYMENT (Current or Previous) 19. INSURED'S POLICY GROUP OR PLAN NUMBER

20. RESERVED FOR NUCC USE 21. AUTO ACCIDENT? PLACE (State) 22. OTHER CLAIM # (Assigned by TRICARE) 23. RESERVED FOR NUCC USE 24. OTHER ACCIDENT? 25. INSURANCE PLAN NAME OR PROGRAM NAME 26. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If yes, complete items 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26)

27. PATIENTS OR AUTHORIZED PERSONS SIGNATURE (Indicate the initials of any medical or other information necessary to process the claim. Also request signature of government benefits officer if typical of the policy, see Sample Assignment below) SIGNED DATE 28. INSURED OR AUTHORIZED PERSONS SIGNATURE (Indicate the initials of any medical or other information necessary to process the claim. Also request signature of government benefits officer if typical of the policy, see Sample Assignment below) SIGNED DATE

29. DATE PATIENT ISABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 30. DATE PATIENT ISABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

31. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) 32. HOW LONG HAS DATE HELD TO CURRENT SERVICE FROM MM DD YY TO MM DD YY 33. REFERENCE LIST 34. REFERENCE LIST 35. REFERENCE LIST

36. MEDICAL CLAIM INFORMATION (Completed by Insured) 37. MEDICAL CLAIM INFORMATION (Completed by Insured) 38. MEDICAL CLAIM INFORMATION (Completed by Insured)

39. 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.) SIGNED DATE 40. SERVICE FACILITY LOCATION INFORMATION a. b.

41. BILLER PROVIDER INFO & PIA () 42. BILLER PROVIDER INFO & PIA ()

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