All Cases For

Understanding Health Insurance A Guide to Billing and Reimbursement 19th Edition 2025 by Michelle A. Green

ANSWER KEY

BlueCross BlueShield Case 1

Required fields: 51

Primary Form

BLUECROSS BLUESHIELD
PO BOX 1121
MEDICAL PA 123571121
CARRIER

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

☐☐☐ PICA PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ZJW334444703

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

3. PATIENT'S BIRTH DATE: MM 01 DD 03 YY 1964 Sex: M ☐ F ☒

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

5. PATIENT'S ADDRESS (No., Street): 2 BIRCH ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 2 BIRCH ROAD

CITY: ELM SPRINGS STATE: NY

8. RESERVED FOR NUCC USE

CITY: ELM SPRINGS STATE: NY

ZIP CODE: 155686789 TELEPHONE (Include Area Code): ( )

ZIP CODE: 155686789 TELEPHONE (Include Area Code): ( )

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: 1155432

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) Yes ☐ No ☒

a. INSURED'S DATE OF BIRTH: MM 01 DD 03 YY 1964 Sex: M ☐ F ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? Yes ☐ No ☒ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? Yes ☐ No ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: BLUECROSS BLUESHIELD

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENTS'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 the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM DD YY: 02 28 YY	QUAL. 431	QUAL.	MM DD YY	MM DD YY FROM	MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
		17b. NPI		MM DD YY FROM	MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? ☐ YES ☒ NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind. 0	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. J180	B.	C.	D.	23. PRIOR AUTHORIZATION NUMBER	
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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02 28 YY		22		99223		A	175 00	1		NPI	
2	03 01 YY		22		99238		A	65 00	1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
111234632	☐ ☒	30022	☒ YES ☐ NO	$ 240 00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (101) 5557754
	CENGAGE HOSPITAL 1 PROVIDER STREET WELLSTONE NY 123451234	ARNOLD YOUNG MD 21 PROVIDER STREET INJURY NY 123472347

SIGNED	DATE	32a.	32b.	33a.	33b.
ARNOLD YOUNG MD	030123	1123456789		0123456789	

ANSWER KEY

BlueCross BlueShield Case 2

Required fields: 44

Primary Form

BLUECROSS BLUESHIELD
PO BOX 1121

MEDICAL PA 123571121

CARRIER

HEALTH INSURANCE CLAIM FORM

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

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PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare#) ☐ (Medicaid#) ☐ (ID#/DoD#) ☐ (Member ID#) ☒ (ID#) ☐ (ID#) ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) XWV779448358
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CHU, JEFFREY, A	3. PATIENT'S BIRTH DATE MM 02 DD 03 YY 2015 Sex M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) CHU, JEFFREY, G
5. PATIENT'S ADDRESS (No., Street) 103 MOUNTAIN VIEW ROAD	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☒ Other ☐	7. INSURED'S ADDRESS (No., Street) 103 MOUNTAIN VIEW ROAD
CITY ELM SPRINGS STATE NY	8. RESERVED FOR NUCC USE	CITY ELM SPRINGS STATE NY
ZIP CODE 155686789 TELEPHONE (Include Area Code) ( )		ZIP CODE 155686789 TELEPHONE (Include Area Code) ( )
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 8762145
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ Yes ☒ No	a. INSURED'S DATE OF BIRTH MM 07 DD 01 YY 1978 Sex M ☒ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ Yes ☒ No	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ Yes ☒ No	c. INSURANCE PLAN NAME OR PROGRAM NAME BLUECROSS BLUESHIELD
d. INSURANCE PLAN NAME OR PROGRAM NAME	d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENTS'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 the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY(LMP)		15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM DD YY: 03 10 YY	QUAL. 431	QUAL.	MM DD YY	FROM MM DD YY	TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
		17b. NPI		FROM MM DD YY	TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? ☐ YES ☒ NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind. 0	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. J209	B. J310	C.	D.	23. PRIOR AUTHORIZATION NUMBER	
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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03 10 YY		11		99212		AB	26 00	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
111397992	☐ ☒	43111	☒ YES ☐ NO	$ 26 00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (101) 5552923
SIGNED SEJAL RAJA MD DATE 030123	a.	SEJAL RAJA MD 1 MEDICAL DRIVE INJURY NY 123472347
	b.	a. 7890123456 b.

PHYSICIAN OR SUPPLIER INFORMATION