



# Network Notification

**Notice Date:** December 23, 2019  
**To:** Ohio Medicaid and MyCare Providers  
**From:** CareSource  
**Subject:** Important Billing Provider Address Reminder

## Summary

As required by the Ohio Department of Medicaid's (ODM) guidelines for Billing Provider Addresses, CareSource will no longer accept any variation of P.O. Box on paper claims in the **Billing Provider Address** box for HCFA-1500(Box 33) and UB-04 (Box 1) forms. A physical address will be required in these fields. This will be effective Jan. 8,2020.

## Guidelines for properly reporting Billing Provider Address on UB04:

<div style="border: 2px solid yellow; padding: 5px; display: inline-block;"> <b>Please enter valid physical address</b> </div>										29 PAT CONT #	4 TYPE OF BILL																																																																				
										5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH																																																																			
8 PATIENT NAME					9 PATIENT ADDRESS																																																																										
10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION	14 ICD-9	15 ICD-9	16 ICD-9	17 STATE	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE																																																												
31 OCCURRENCE DATE	32 CODE	33 OCCURRENCE DATE	34 CODE	35 OCCURRENCE DATE	36 CODE	37 OCCURRENCE DATE	38 CODE	39 OCCURRENCE DATE	40 CODE	41 OCCURRENCE DATE	42 CODE	43 OCCURRENCE DATE	44 CODE	45 OCCURRENCE DATE	46 CODE	47 OCCURRENCE DATE	48 CODE	49 CODE	50 CODE																																																												
38										39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT																																																																	
42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / ICD-9 CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COMPRD CHARGES										49									
PAGE										OF										CREATION DATE										TOTALS																																																	
50 PAYER NAME					51 HEALTH PLAN ID					52 REL. BILL					53 MARK. 25%					54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI																																																	
56 INSURED'S NAME					57 PIPED					58 INSURED'S UNIQUE ID					59 GROUP NAME					60 INSURANCE GROUP NO.																																																											
61 TREATMENT AUTHORIZATION CODES										62 DOCUMENT CONTROL NUMBER										63 EMPLOYER NAME																																																											
64										65										66																																																											
67										68										69																																																											
70 ADMIT DX					71 PATIENT REASON DX					72 OTHER PROCEDURE DATE					73 OTHER PROCEDURE DATE					74 OTHER PROCEDURE DATE					75 OTHER PROCEDURE DATE					76 ATTENDING NPI					77 QUAL																																												
76 LAST					77 FIRST					78 LAST					79 FIRST					80 LAST					81 FIRST					82 LAST					83 FIRST																																												
80 REMARKS					81					82					83					84					85					86					87																																												

# Guidelines for properly reporting Billing Provider Address on HCFA-1500:



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (AD#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S ID NUMBER (For Program in Item 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No. Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No. Street)											
CITY			STATE		8. RESERVED FOR NUCC USE					CITY		STATE							
ZIP CODE			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							
10a. OTHER INSURED'S POLICY OR GROUP NUMBER			10b. RESERVED FOR NUCC USE		10c. RESERVED FOR NUCC USE		10d. INSURANCE PLAN NAME OR PROGRAM NAME		10e. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			10f. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
10g. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			10h. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		10i. CLAIM CODES (Designated by NUCC)		10j. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		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.							
SIGNED _____ DATE _____					SIGNED _____														
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE MM DD YY QUAL.					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate #IC to service line below (24E)										ICD #nd.		22. RESUBMISSION CODE ORIGINAL REF. NO.							
A. _____		B. _____		C. _____		D. _____		E. _____		F. _____		G. _____		H. _____		I. _____		J. _____	
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. UNIT FEE/Rate		I. IN. QUAL.		J. RENDERING PROVIDER ID, #	
25. FEDERAL TAX ID NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rev'd for NUCC Use							
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 # ( )									
SIGNED _____ DATE _____					a. NPI b.					a. NPI b.									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

### Questions?

For questions, please visit [www.medicaid.ohio.gov](http://www.medicaid.ohio.gov)>Resources>Publications> ODM Guidance> [ODM Hospital Billing Guidelines](#).