

Network Notification

Date: June 25, 2014

Number: KY-P-2014-15

To: Participating Health Care Providers

From: Humana – CareSource® (KY) Medicaid

Subject: Provider ID Requirements for Paper Claim Forms

Humana – CareSource is pleased to work with you to serve our members and we are dedicated to providing you with the best service and support possible.

To facilitate the accurate and prompt payment of claims, please use your federal tax identification number (TIN) and national provider identifier (NPI) when submitting claims to Humana – CareSource.

Use the Humana – CareSource provider billing number to register on the provider portal at www.caresource.com/providers/kentucky/providerportal.

Please include these numbers when completing the following forms:

CMS-1500 – Typical Providers:

Box 24i: (Shaded) ZZ qualifier for rendering provider taxonomy

I.	J.
ID. QUAL.	RENDERING PROVIDER ID. #
NPI	
NPI	

Box 24j: (Unshaded) Rendering provider taxonomy

I.	J.
ID. QUAL.	RENDERING PROVIDER ID. #
NPI	
NPI	

33. BILLING PROVIDER INFO & PH # ()

a.	b.
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Box 33b: (Shaded) Billing provider taxonomy

33. BILLING PROVIDER INFO & PH # ()

a. b.

[illegible]

Atypical providers using CMS-1500 **do not** use NPI or taxonomy. Atypical providers should complete as follows:

25. FEDERAL TAX I.D. NUMBER SSN EIN

Box 33a: G2 qualifier

a.	b.
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33. BILLING PROVIDER INFO & PH # ()

a. b.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NLUCC) 01/12

PICA												PICA	
1. MEDICARE (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare)												15. INSURER'S U.S. NUMBER (For Programs in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												16. INSURER'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S ADDRESS (St., New)												17. INSURER'S ADDRESS (St., New)	
4. CITY												18. CITY	
5. STATE												19. STATE	
6. ZIP CODE												20. ZIP CODE	
7. TELEPHONE (Include Area Code)												21. TELEPHONE (Include Area Code)	
8. OTHER INSURER'S NAME (Last Name, First Name, Middle Initial)												22. OTHER INSURER'S NAME (Last Name, First Name, Middle Initial)	
9. OTHER INSURER'S POLICY OR GROUP NUMBER												23. OTHER INSURER'S POLICY OR GROUP NUMBER	
10. RESERVED FOR NLUCC USE												24. RESERVED FOR NLUCC USE	
11. RESERVED FOR NLUCC USE												25. RESERVED FOR NLUCC USE	
12. INSURANCE PLAN NAME OR PROGRAM NAME												26. INSURANCE PLAN NAME OR PROGRAM NAME	
13. READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM. (Indicate the following or provide other information as requested on this form. It also may require payment of premium for benefits which is subject to the policy with acceptable medical history.)												14. READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM. (Indicate the following or provide other information as requested on this form. It also may require payment of premium for benefits which is subject to the policy with acceptable medical history.)	
15. OTHER DATE (Date)												16. OTHER DATE (Date)	
17. DATE OF CURRENT CLAIM, INJURY, OR PRESENTLY EMPLOYED (Date)												18. DATE OF CURRENT CLAIM, INJURY, OR PRESENTLY EMPLOYED (Date)	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (Last Name, First Name, Middle Initial)												20. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (Last Name, First Name, Middle Initial)	
21. ADDITIONAL CLAIM INFORMATION (Designated by NLUCC)												22. ADDITIONAL CLAIM INFORMATION (Designated by NLUCC)	
23. DATE OF ONSET OF INJURY (Date)												24. DATE OF ONSET OF INJURY (Date)	
25. DATE OF SERVICE (Date)												26. DATE OF SERVICE (Date)	
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99. DATE OF SERVICE (Date)												100. DATE OF SERVICE (Date)	

NLUCC Instruction Manual available at: www.nlucc.org

PLEASE PRINT OR TYPE

01-010-1187 FORM 1500 (02)

UB-04:

Box 81: Billing provider taxonomy

81CC			
a			
b			
c			
d			

The image shows a UB-04 form with a blue arrow pointing from the '81CC' field in the 'Box 81: Billing provider taxonomy' section to the 'a' field in the '81CC' field of the UB-04 form.

ADA:

Box 49: Billing provider NPI

49. NPI

The image shows the ADA American Dental Association Dental Claim Form. A blue arrow points from the '49. NPI' field in the 'Box 49: Billing provider NPI' section to the 'NPI' field in the 'PATIENT INFORMATION' section of the ADA form.

Box 52a: Billing provider taxonomy

52a. Additional Provider ID

54. NPI

Box 56a: Rendering provider taxonomy

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ADA Form 100 (Rev. 10/11) (ADA Form 100, ADA Form 100, ADA Form 100, ADA Form 100)
To reorder call 800.947.4746
or go online at ada.org/catalog

To avoid delay or disruption of claims payments, please share this information with individuals involved in claims and billing for your organization, billing vendors and/or electronic claims clearinghouses. When submitting an electronic claim to one of our clearinghouses, be sure to include the Humana – CareSource electronic payer ID number KYCS1.

Visit the provider website at <http://www.caresource.com/providers/kentucky> to find claim filing instructions, provider orientation materials, the provider manual, reference forms and more.

If you have questions, please call your Humana – CareSource provider relations representative directly or call **1-855-852-7005**, Monday through Friday, 8 a.m. to 6 p.m. Eastern time and select the appropriate menu options.

Thank you for your care of our members.

KY-P-242