THE OHIO STATE UNIVERSITY
HEALTH PLAN

Claim Form Completion Instructions for Professional Services

These instructions outline information **required** for reimbursement, and so the following boxes **must** contain your information; you may complete other boxes not noted if you have the information. Contact Luminare Health at 1-866-442-8257 with questions or for assistance in form completion.

- Proof of payment is required for services to be eligible for reimbursement
- Keep a copy of the completed claim form, itemized statement(s), and receipt(s) for your records.

Box 1a: Enter Health Plan Member Identification Number.

Box 2: Print patient name (Last name, First name, Middle initial).

Box 3: Enter patient date of birth (Month, Date, Year).

Box 3: Choose patient sex (M=male, F=female).

Box 4: Print Health Plan Member (OSU/OSUWMC Employee Name) (Last name, First name, Middle initial).

Box 21: On lines A – L; enter diagnosis code(s) as indicated by the rendering provider/physician, enter one (1) code per line.

Box 24A. Starting with row 1, enter date of provider/physician service (if multiple dates apply, list individually, with the respective service on rows 2 – 6).

Box 24B. Enter the following number to describe the place you received services:

- 11 - if services were received in the provider/physician office
- 12 - if services were provided in your home
- 22 - if services were received in an outpatient area of a hospital

Box 24D. Enter the service code describing the services received (identified by the provider/physician usually listed on your receipt or itemized statement), contact your provider/physician if no service code(s) provided.

Box 24F. Enter the amount you were charged for the service.

Box 25. Enter the provider/physician federal tax identification number listed on your itemized statement – contact your provider/physician if no tax identification is listed.

Box 28. Enter the total amount charged.

Box 31. Print provider/physician name and date.

Box 32. Enter Pay to EE (*this means the employee will receive the reimbursement).

Box 33. Print provider/physician billing address and telephone number.

Submit completed claim form, itemized statement(s), and receipt(s) via mail to
Luminare Health
ATTN: OSU Health Plan Member Claims
PO Box 4386
Clinton, IA 52733

Completed claim form, itemized statement(s), and receipt(s) can also be submitted electronically via email to:
OSUMemberSubmissions@luminarehealth.com

HEALTH INSURANCE CLAIM FORM

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

Luminare Health
PO Box 4386
Clinton, IA 52733

PICA

PICA

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)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY 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

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. 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. 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.

SIGNED _____ 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) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 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.

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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										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) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Clear Form

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION