

FAMILY CARE SERVICES CLAIM FORM KEY

In order to process your claims accurately and timely, please refer to the information below when completing your claim forms. Incomplete claims may result in a delay in processing. Fields marked with "*" are mandatory for processing.

Field	What To Enter
Member/Client Name *	Name (first, middle initial and last) of NorthernBridges client
Member ID Number *	Client's NorthernBridges number
DOB	Client's date of birth (mm/dd/yyyy)
Gender	Male or female
Billing Provider Name *	Name of billing entity
Billing/Remit Address *	Address where payment should be sent
City, State & Zip *	City, state and zip code of billing provider
Tax ID Number *	Federal Tax ID number or social security number under which you bill
NPI (if applicable)	National Provider Identifier (assigned to most licensed medical providers)
Rendering Provider*	Name of person providing services if different from billing provider
Rendering Provider NPI*	National Provider Identifier assigned to provider (if applicable)
Place of Service (choose one)*	11 - Provider's office
	12 - Client's home
	99 - Other
Authorization #	Number which authorizes services; can be located on the authorization letter created by the Care Manager.
HIPAA/Service Code *	HIPAA code provided by NorthernBridges which can be located on the letter that authorizes services. It must be a 5-digit/character code.
Modifier 1 and 2 * (if applicable)	2-digit/character code that provides specific information relating to HIPAA code (if applicable); located on the authorization letter after the HIPAA code.
Date of Service From *	Date of service from; <u>must</u> be in mm/dd/yyyy format.
Date of Service To *	Date of service to; <u>must</u> be in mm/dd/yyyy format.
Rate Per Day/Unit *	Dollar amount/rate per day or unit.
# Days/Units *	Quantity or unit of measure (MUST BE <u>WHOLE</u> UNITS)
Total Billed Amt. *	Billed amount for services on that line
Grand Total *	Total of all service lines