

### STEP 1:

Select a claims-based quality measure you would like to report on.

Visit <https://www.aad.org/member/practice/mips/measures> to find a measure reportable through claims.

### STEP 2:

Review the selected measure specification to verify that you have met the performance requirements and to determine applicable quality data code(s) (QDC).

### STEP 3:

Complete the form following steps 4, 5, 6, and 7. *This example is not intended to be used for official reporting.*

### STEP 4:

Complete this part of the claim form with patient demographics and insurance information:

- Name
- Address
- ID Number
- Secondary insurance information
- Etc.

### STEP 5:

Enter patient's diagnosis code(s) in section 21.

### STEP 6:

- A. Enter date of service.
- B. Enter place of service.
- C. Leave blank
- D. Enter appropriate CPT code (with modifier if appropriate) and G-code for selected measure.
- E. Link corresponding letters from diagnosis only to MIPS quality data codes when applicable to MIPS measure in section 21.
- F. Codes from box 24D must be accompanied by a line-item charge of \$0.01 in box 24F.

### STEP 7:

Complete this part of the claim form as usual.

2017 by The Centers for Medicare & Medicaid Services.

### HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare #) (ICM0000)		2. MEDICAID (Medicaid #) (ICM0000)		3. TRICARE (Tricare #) (ICM0000)		4. CHAMPVA (Champion #) (ICM0000)		5. GROUP HEALTH PLAN (ICM0000)		6. PICA (PICA #) (ICM0000)		7. OTHER (ICM0000)		8. INSURED'S I.D. NUMBER (after Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE (MM / DD / YY)				4. INSURED'S NAME (Last Name, First Name, Middle Initial)				5. INSURED'S BIRTH DATE (MM / DD / YY)			
5. PATIENT'S ADDRESS (No. / Street)				6. PATIENT RELATIONSHIP TO INSURED (Self / Spouse / Child / Other)				7. INSURED'S ADDRESS (No. / Street)				8. INSURED'S DATE OF BIRTH (MM / DD / YY)			
CITY				STATE				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 PICA NUMBER				12. INSURED'S DATE OF BIRTH (MM / DD / YY)			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				b. EMPLOYMENT (Current or Previous)				c. INSURED'S DATE OF BIRTH (MM / DD / YY)				d. INSURED'S DATE OF BIRTH (MM / DD / YY)			
b. RESERVED FOR NUCC USE				c. AUTO ACCIDENT? (PLACE DATE)				e. OTHER ACCIDENT?				f. INSURED'S PLAN NAME OR PROGRAM NAME			
c. RESERVED FOR NUCC USE				d. OTHER ACCIDENT?				g. IS THERE ANOTHER HEALTH BENEFIT PLAN?				h. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)			
d. INSURANCE PLAN NAME OR PROGRAM NAME				e. RESERVED FOR LOCAL USE				i. YES / NO				j. YES / NO			
<p>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</p> <p>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.)</p> <p>SIGNED _____ DATE _____</p> <p>13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) (MM / DD / YY)</p> <p>14. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial)</p> <p>15. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p> <p>16. DATE OF SERVICE (MM / DD / YY)</p> <p>17. PLACE OF SERVICE (ICD-9-CM-3)</p> <p>18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD-9-CM-3)</p> <p>19. CPT CODE (ICD-9-CM-3)</p> <p>20. G-CODE (ICD-9-CM-3)</p> <p>21. DATE OF SERVICE (MM / DD / YY)</p> <p>22. PLACE OF SERVICE (ICD-9-CM-3)</p> <p>23. CPT CODE (ICD-9-CM-3)</p> <p>24. G-CODE (ICD-9-CM-3)</p> <p>25. DATE OF SERVICE (MM / DD / YY)</p> <p>26. 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