

## Step 1:

# ADMINISTRATION CLAIM

- This claim should include only the administration codes, office call or other charges.
- Vaccine codes and modifiers should NOT be included on this claim.

**SAMPLE**

**Administration Claim Form to submit to payer with DBA Data Form**

1500  
HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PCIA  (Medicare #)  (Medicaid #)  (TRICARE CHAMPUS Sponsor's SSN)  (CHAMPVA Member ID)  (GROUP HEALTH PLAN SSN or ID)  (FECA BOXING SSN)  (OTHER (NO))

18. INSURED'S I.D. NUMBER (For Program in Item 1) \_\_\_\_\_

1. 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. PATIENT STATUS  
Single  Married  Other

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:  
a. EMPLOYMENT? (Current or Previous) YES  NO   
b. AUTO ACCIDENT? YES  NO  PLACE (State) \_\_\_\_\_  
c. OTHER ACCIDENT? YES  NO

11. INSURED'S POLICY GROUP OR FECA NUMBER \_\_\_\_\_

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of information to the payer for processing this claim. I also request payment of government benefits other to myself below.  
SIGNED \_\_\_\_\_

13. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY) \_\_\_\_\_

14. EMPLOYER'S NAME OR SCHOOL NAME \_\_\_\_\_

15. IF PATIENT GIVE FILE \_\_\_\_\_

16. INSURANCE PLAN NAME OR PROGRAM NAME \_\_\_\_\_

10d. RESERVED FOR LOCAL USE \_\_\_\_\_

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (State, NPI) \_\_\_\_\_

19. RESERVED FOR LOCAL USE \_\_\_\_\_

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Recode Items 1, 2, 3 & 4 to 1-4)  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

23. PRIOR AUTHORIZATION NUMBER \_\_\_\_\_

	A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY)	B. ICD-9-CM PROCEDURE CODE (SERV)	C. ICD-9-CM EMJ CODE (EMJ)	D. PROCEDURE, DRUG, OR SUPPLY (Explain Unusual Codes) (CPT/HCPCS)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF SERVICE	H. ICD-9-CM PARTIAL DAY	I. I.D. QUAL.	J. RENDERING PROVIDER ID #
1	5/1/2010 - After			90471		Providers			NPI	
2				90472		Providers			NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER \_\_\_\_\_

26. PATIENT'S ACCOUNT NO. \_\_\_\_\_

27. ACCEPT ASSIGNMENT? (Print amount on back) YES  NO

28. TOTAL CHARGE \$ \_\_\_\_\_

29. AMOUNT PAID \$ \_\_\_\_\_

30. BALANCE DUE \$ \_\_\_\_\_

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (Identify 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 \_\_\_\_\_

NJCC Instruction Manual available at: [www.njcc.org](http://www.njcc.org) PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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**SAMPLE**  
**DBA Data Form**  
 to submit to payer

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE (Medicare #) <input type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/>		CHAMPVA (Member ID) <input type="checkbox"/>		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA (SSN) <input type="checkbox"/>		OTHER (ID) <input type="checkbox"/>		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 <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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY				STATE			
ZIP CODE				TELEPHONE (Include Area Code)		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE				TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. OTHER INSURED'S POLICY OR GROUP NUMBER						11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.							
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 RECEIVED: FROM _____ TO _____		17a. ICD-9-CM PROCEDURE CODE		17b. ICD-9-CM DIAGNOSIS CODE		17c. ICD-9-CM MODIFIER		17d. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES							
19. RESERVED FOR LOCAL USE						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refile items 1, 2, 3 on 4 to item 24E by line)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
1						3						23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From DD YY MM DD To DD YY		B. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLIES (Specify Unusual Circumstances) CRT/PCS MODIFIER		D. DIAGNOSIS POINT		E.		F. \$ CHARGES		G. OUTS OF STATE		H. CREDIT RISK		I. QUAL		J. RENDERING PROVIDER ID #	
1 5/1/2010 - After		2 Vaccine		3 Assessment charge based on 07/01/2015 grid															
4 27-2251833		7 Pt. Acct # w/Provider																	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (Certify that the statements on the reverse apply to this bill and are made a part thereof)						32. SERVICE FACILITY LOCATION INFORMATION						33. TOTAL CHARGE \$							
Leave Blank						5 Washington Vaccine Association PO Box 94002 Seattle, WA 98124-8402						34. AMOUNT PAID \$							
35. BALANCE DUE \$																			

CARRIER  
 PATIENT AND INSURED INFORMATION  
 PHYSICIAN OR SUPPLIER INFORMATION

# Step 2: DBA FORM

- Most fields same as in administration claim, but this DBA form must include:



**SAMPLE**  
**DBA Data Form**  
 to submit to payer

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 04/05

1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA RELYING (SSN) <input type="checkbox"/> OTHER (IC) <input type="checkbox"/>		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 <input type="checkbox"/> F <input type="checkbox"/>	
4. PATIENT'S ADDRESS (No., Street)		5. INSURED'S NAME (Last Name, First Name, Middle Initial)	
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)	
8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		8. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. INSURED'S POLICY GROUP OR FECA NUMBER	
10. OTHER INSURED'S POLICY OR GROUP NUMBER		10. PATIENT'S CONDITION RELATED TO:	
11. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>		11. EMPLOYMENT? (Current or Previous) (Yes <input type="checkbox"/> No <input type="checkbox"/>	
12. EMPLOYER'S NAME OR SCHOOL NAME		12. AUTO ACCIDENT? (Yes <input type="checkbox"/> No <input type="checkbox"/> PLACE (State) _____	
13. INSURANCE PLAN NAME OR PROGRAM NAME		13. OTHER ACCIDENT? (Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any information to process this claim. I also request payment of government benefits either to myself or to below.)		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, return to and complete item 9 a-d.	
15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)		15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any information to process this claim. I also request payment of government benefits either to myself or to below.)	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. CURRENT OCCUPATION (TO MM DD YY)	
17. RESERVED FOR LOCAL USE		17. TO CURRENT SERVICES (TO MM DD YY)	
18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to Items 1, 2, 3 or 4 to Item 24E by Line #)		18. CHARGES	
19. RESERVED FOR LOCAL USE		19. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
20. RESERVED FOR LOCAL USE		20. PRIOR AUTHORIZATION NUMBER	
21. DATES OF SERVICE (From DD YY MM DD To YY MM DD) PLACE OF SERVICE (A-J) PROCEDURE, SEVICE OR SUPPLIES (Explain Unusual or Complex) MODIFIER		21. CHARGES (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)	
22. 5/1/2010 - After		22. Vaccine	
23. 27-2251833		23. Assessment charge based on 07/01/2015 grid	
24. 27-2251833		24. Pt. Acct # w/Provider	
25. Leave Blank		25. Service Provider's Info	
26. Washington Vaccine Association		26. PO Box 94002	
27. Seattle, WA 98124-8402		27. Seattle, WA 98124-8402	

CPT code for state supplied vaccine. NO modifiers.

# Step 2: DBA FORM

- Most fields same as in administration claim, but this DBA form must include:
  2. Box 24D: CPT code for the state-supplied vaccine given. **NO** modifiers.

**SAMPLE**  
**DBA Data Form**  
 to submit to payer

1500  
**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA (SSN) <input type="checkbox"/> OTHER (IC) <input type="checkbox"/>		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 <input type="checkbox"/> F <input type="checkbox"/>	
4. PATIENT'S ADDRESS (No., Street)		5. INSURED'S NAME (Last Name, First Name, Middle Initial)	
6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. INSURED'S ADDRESS (No., Street)	
7. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. EMPLOYED (Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		8. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. INSURED'S POLICY GROUP OR FECA NUMBER	
10. OTHER INSURED'S POLICY OR GROUP NUMBER		10. PATIENT'S CONDITION RELATED TO:	
11. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>		11. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
12. EMPLOYER'S NAME OR SCHOOL NAME		12. EMPLOYER'S NAME OR SCHOOL NAME	
13. INSURANCE PLAN NAME OR PROGRAM NAME		13. INSURANCE PLAN NAME OR PROGRAM NAME	
14. 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.)		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. INABLE TO WORK IN CURRENT OCCUPATION (MM DD YY TO MM DD YY)	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES RELATED TO CURRENT SERVICES (MM DD YY TO MM DD YY)	
17. RESERVED FOR LOCAL USE		17. \$ CHARGES	
18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to Items 1, 2, 3 or 4 to Item 24E by Line)		18. PAID RESUBMISSION ORIGINAL REF. NO.	
19. 1. _____ 3. _____		19. AUTHORIZATION NUMBER	
20. A. DATE(S) OF SERVICE (From DD YY MM DD To YY) B. PLACE OF SERVICE C. D. PROCEDURES, SERVICICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS (ICD-9-CM) F. CHARGES G. UNITS H. ICD-9-CM QUAL I. RENDERING PROVIDER ID #		20. J. RENDERING PROVIDER ID #	
1 5/1/2010 - After Vaccine		3 Assessment charge based on 07/01/2015 grid	
2		4	
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5		7	
6		8	
7 27-2251833		8 Pt. Acct # w/Provider	
9 Leave Blank		9 Service Provider's Info	
10		10 Washington Vaccine Association	
11		11 PO Box 94002	
12		12 Seattle, WA 98124-8402	
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49		49	
50		50	

WVA  
Assessment Charge

## Step 2: DBA FORM

- Most fields same as in administration claim, but this DBA form must include:
  2. Box 24D: CPT code for the state-supplied vaccine given. NO modifiers.
  3. Box 24F: WVA assessment charge based on 07/01/2015 grid.



**SAMPLE**  
**DBA Data Form**  
 to submit to payer

1500  
**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPVA (Sponsor's SSN)		CHAMPVA (Member ID)		GROUP HEALTH PLAN (SSN or ID)		FECA BENEFITING (IC)		OTHER (IC)		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 <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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE																																																																																																																																																																			
ZIP CODE				TELEPHONE (Include Area Code)				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE				TELEPHONE (Include Area Code)																																																																																																																																																																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. OTHER INSURED'S POLICY OR GROUP NUMBER						11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY																																																																																																																																																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																							
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 9 a-d.																																																																																																																																																																							
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 _____ DATE _____																																																																																																																																																																							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE				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. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																			
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refile Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																	
23. PRIOR AUTHORIZATION NUMBER						24. A. DATES OF SERVICE From DD YY MM DD To DD YY MM DD						B. PLACE OF SERVICE (Specify)						C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances)						E. DIAGNOSIS (ICD-9-CM)						F. CHARGES						G. UNITS						H. RATE						I. ID. QUAL.						J. RENDERING PROVIDER ID. #																																																																																																																													
1 5/1/2010 -						2						3						4						5						6						7						8						9						10						11						12						13						14						15						16						17						18						19						20						21						22						23						24						25						26						27						28						29						30					
4 27-2251833						7 Pt. Acct # w/Provider						28. TOTAL CHARGE \$						29. AMOUNT PAID \$						30. BALANCE DUE \$						31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>Leave Blank</b>						32. SERVICE FACILITY LOCATION INFORMATION 6 Service Provider's Info						33. WASHINGTON VACCINE ASSOCIATION 5 Washington Vaccine Association PO Box 94002 Seattle, WA 98124-8402																																																																																																																																									

# Step 2: DBA FORM

- Most fields same as in administration claim, but this DBA form must include:
  - Box 24D: CPT code for the state-supplied vaccine given. NO modifiers.
  - Box 24F: WVA charge based on 07/01/2015 grid.
  - Box 25: WVA Tax ID Number (TIN): 27-2251833

**SAMPLE**  
**DBA Data Form**  
 to submit to payer

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 04/05

1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPVA (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA (SSN) <input type="checkbox"/> OTHER (IC) <input type="checkbox"/>		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 <input type="checkbox"/> F <input type="checkbox"/>	
4. PATIENT'S ADDRESS (No., Street)		5. INSURED'S NAME (Last Name, First Name, Middle Initial)	
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)	
8. PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		8. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. INSURED'S POLICY GROUP OR FECA NUMBER	
10. OTHER INSURED'S POLICY OR GROUP NUMBER		10. PATIENT'S CONDITION RELATED TO:	
11. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>		11. EMPLOYMENT? (Current or Previous) (YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. EMPLOYER'S NAME OR SCHOOL NAME		12. AUTO ACCIDENT? (YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
13. INSURANCE PLAN NAME OR PROGRAM NAME		13. OTHER ACCIDENT? (YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>		14. RESERVED FOR LOCAL USE	
15. EMPLOYER'S NAME OR SCHOOL NAME		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete Item 9 a-d.	
16. INSURANCE PLAN NAME OR PROGRAM NAME		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
17. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		17. SIGNED _____ DATE _____	
18. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		18. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)	
19. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	
20. RESERVED FOR LOCAL USE		20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refile Items 1, 2, 3 or 4 to Item 24E by Line)		21. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
22. 1. _____ 3. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
23. 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER _____	
24. A. DATE(S) OF SERVICE (From DD YY MM DD To YY MM DD) B. PLACE OF SERVICE (F, I, O, P, S, U, V, W, X, Y, Z) C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. CHARGES (ICD-9-CM) G. DRUGS OR SUPPLIES (ICD-9-CM) H. ICD-9-CM QUALIFIER I. RENDERING PROVIDER ID # J. RENDERING PROVIDER ID #		24. A. DATE(S) OF SERVICE (From DD YY MM DD To YY MM DD) B. PLACE OF SERVICE (F, I, O, P, S, U, V, W, X, Y, Z) C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (ICD-9-CM) F. CHARGES (ICD-9-CM) G. DRUGS OR SUPPLIES (ICD-9-CM) H. ICD-9-CM QUALIFIER I. RENDERING PROVIDER ID # J. RENDERING PROVIDER ID #	
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WVA Name and Address

## Step 2: DBA FORM

- Most fields same as in administration claim, but this DBA form must include:
  2. Box 24D: CPT code for state-supplied vaccine given. NO modifiers.
  3. Box 24F: WVA charge based on 07/01/2015 grid.
  4. Box 25: Vaccine Association tax ID number: 27-2251833
  5. Box 33: Washington Vaccine Association; PO Box 94002; Seattle, WA 98124-8402