Claim Requirements for Claim Submission

- All paper claims **must be typewritten**. Given the differences in handwriting and other factors impacting legibility, we can no longer accept handwritten claims. **DO NOT** handwrite a signature in Box 31. The name must be typewritten as well.

- Paper claims should be submitted on the **UB04**, **DHS Transportation Billing form**, or the following versions of the **CMS 1500**:
  - Red line forms—these are the "original" forms, not photo copies
  - No line forms—these are available on a variety of websites, and can be printed from QClaims.

- Typed information must be completely within the boxes on the claim form. Information typed directly on the lines will cause errors in processing your claims and could result in claims being denied due to an inability to accurately read the information on the form.

  *Please note: The inability to accurately read the information on the form will result in the claim form being returned to the submitter.

Please refer to the table displayed below as a quick reference. The table displays the information required on a claim submitted to the EICBO and the appropriate box to present the information in. The format in which the information should be displayed is listed as well. Review the EI-CBO Billing Information for Providers document for a complete listing of billing requirements.

Required Information on an EI-CBO Claim Form	
Child's Name	**Units—NOT MINUTES (15 minutes = 1 unit)**
• Last name, First name—Alpha characters ONLY • CMS 1500 form – box 2 • UB04 billing form – box 8	• Numeric • CMS 1500 form – box 24G • UB04 billing form – box 46
Child's EI number	**Billed amount**
• 6 digit numeric ONLY (DO NOT include "EI #" in the box) • CMS 1500 form – box 1A • UB04 billing form – box 60	• Numeric • CMS 1500 form – box 24F • B04 billing form – box 47
Child's current address	**Total billed amount**
• Alpha/numeric • CMS 1500 form – box 5 • UB04 billing form – box 9	• Numeric • CMS 1500 form – box 28 • UB04 billing form – box 47
Referring Provider's Name (when required)	**Enrolled provider who performed service**
• DN First Name Last Name (DO NOT include middle name/initial or suffix)-Alpha Only • CMS 1500 form – box 17 • UB04 billing form – box 78	• Last name , first name—Alpha Only • CMS 1500 form – box 31 • UB04 billing form – box 80
Referring Provider's NPI# (when required)	**Associate provider's name (if applicable)**
• Numeric—No Dashes • CMS 1500 form – box 17b • UB04 billing form – box 78	• Last name, first name—Alpha Only • CMS 1500 form – box 19 • UB04 billing form – box 80

Diagnosis code	**Provider tax ID/SS#**
• Alpha/numeric • CMS 1500 form – box 21 • UB04 billing form – box 66	• Numeric—No Dashes • CMS 1500 form – box 25 • UB04 billing form – box 5
Date of service	**Provider billing address**
• mm dd yy format ONLY—Numbers Only • CMS 1500 form – box 24A • UB04 billing form – box 45	• Alpha/numeric • CMS 1500 form – box 33 • UB04 billing form – box 1
Place of service	**Patient account number (optional)**
• 2 digit Numeric code • CMS 1500 form – box 24B • UB04 billing form – box 57	• Alpha/numeric • CMS 1500 form – box 26 • UB04 billing form – box 3
CPT/HCPCS procedure code	**Interpretation services**
• 5 digit Numeric/alpha-numeric code • CMS 1500 form – box 24D • UB04 billing form – box 44	• Two digit description of service interpreted (such as PT, ST, etc.) Alpha code • CMS 1500 form – box 23 • UB04 billing form – box 80
Modifier (when required)	**NPI Number**
• Alpha code • CMS 1500 form – box 24D • UB04 billing form – box 44	• Numeric • CMS 1500 form – box 24J • UB04 billing form – box 56

Mail paper claims to:
Early Intervention
Central Billing Office
P.O. Box 19485
Springfield, IL 62794-9485