

Be advise that before a bill can be considered “acceptable” for payment by the Victim Compensation and Government Claims Board, the following sections must be completed correctly or the bill will be returned and payment may be delayed

Section Number on CMS 1450 Form	Information listed below is needed in each section to process your bill
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1	Provider Name/Address
3	Claimant’s/Patient’s Account Number
5	Tax ID/SSN/FEIN Number of Payee as Registered with IRS
6	Dates of Services
12	Claimant’s/Patient’s Name
13	Claimant’s/Patient’s Address
38	Claimant’s/Patient’s Name and Address
43-46	Itemized Expenses
47	Total Charges/Billed Amount
58	Claimant’s/Patient’s Name
60*	Claimant’s VCP Claim Number/SSN
67	Primary Diagnosis Code
82 & 85	Physician’s Name/License Number/Signature/Date

*** Claim Number is not required if not listed.**

ATTENTION ALL PROVIDERS ALREADY IN OUR SYSTEM: Number 1 and Number 5 on your bill must match exactly to what is in the system. If YOU/PROVIDER has a new Tax Id please notify the Program immediately

1		2		3 PATIENT CONTROL NO.		4 TYPE OF BILL	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH		7 COV D.		8 N-C D.	
9 PATIENT NAME		10 PATIENT ADDRESS		11		10 L.R.D.	
14 BIRTH DATE		15 SEX		16 M/S		17 DATE	
18 ADMISSION		19 HR		20 SRC		21 D HR	
22 STAY		23 MEDICAL RECORD NO.		24		25	
26		27		28		29	
30		31		32		33	
34 OCCURRENCE DATE		35 OCCURRENCE TIME		36 OCCURRENCE DATE		37 OCCURRENCE TIME	
38		39		40		41	
42 REV. CO.		43 DESCRIPTION		44 HCPCS / RATES		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
50 PAYER		51 PROVIDER NO.		52 REL INFO		53 ASG BEN	
54 PRIOR P. PAYMENTS		55 EST. AMOUNT DUE		56		57	
58 INJURED'S NAME		59 A REL		60 CERT. - SSN - HIC - 10 NO.		61 GR CLIP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME	
66 EMPLOYER LOCATION		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82 ATTENDING PHYS. ID		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	