insuranceTPA.com℠
ADMINISTRATORS

Claims Customer Service
PO Box 998, Janesville WI, 53547
Phone: 1-800-279-2290
claims@insurancetpa.com

INSTRUCTIONS FOR SELF CLAIM FORM SUBMISSION

The following are steps to submitting a claim yourself...

1. Please have your provider complete a HCFA–1500 form (non-hospital claims) for **services that have been paid for.** You may need to contact your provider to obtain the diagnosis code(s) (Box 21) and procedure code(s) (Box 24D), Place of Service Number (Box 24B), and Federal Tax ID (Box 25) that are required to complete the required fields on this form.

If you have a hospital claim we require that the hospital submit the UB claim form for processing.

- BOX 1a~Insured ID, Policy or Certificate number
- BOX 2 through Box 8~Complete with current information regarding the patient and the insured.
- BOX 9~Leave blank
- BOX 10~a, b, and c answer these specific questions regarding specificity to this particular claim.
- BOX 11~a, b, c, d
- BOX 12~Signature of insured/claimant
- BOX 13~Leave blank
- **BOX 21~Diagnosis codes are why you were being seen and should be given to you by the provider and will coincide with the procedure codes in box 24D.**
- BOX 24A~Treatment performed by **different provider(s) should be submitted with a different claim** form for each provider of service.
- **BOX 24B~Place of Service Number**
- **BOX 24D~Procedure codes are assigned by the provider, each procedure code must have a diagnosis code and may be different for each date of service.**
- BOX 24E~These diagnosis codes come from BOX 21 and should match the date of serice.
- BOX 24F~Charges are for services rendered. Proof of payment by the insured must be suported by documentation provided by the provider seen.
- BOX 25~ **Federal Tax ID number must be entered. This number is specific to each provider and regardless must be entered for each provider.**
- BOX 27~ Check "No"
- BOX 28~This is the total charge for the visit.
- BOX 29~This is the total paid to the provider.
- BOX 30~This is the balance due to the provider. We are required to pay the provider of service if there is a balance due. Please send any documentation that these charges have been paid in full. (example: receipt, invoice or super bill that shows payment from claimant)
- BOX 32~Facility Name, Address and phone number must be entered in this box. It is very important that we have information for contacting the provider in case more information is required.
- BOX 33~Billing Name and Address is required to be entered for payment. Who is to receive payment?

See back side for mailing instructions

2. Make a copy for your records, **ATTACH PROOF OF PAYMENT**, and mail to:

InsuranceTPA.com
Attn: CLAIMS DEPARTMENT
PO Box 998, Janesville WI, 53547

If you have claims questions about a submitted claim, your eligibility or your benefits, please call (800) 279-2290

The hours of operation at InsuranceTPA.com, Inc Customer Service Hours are 8:30 am - 5:00 pm CST

Monday-Friday.
claims@insurancetpa.com

Thank you!

InsuranceTPA.com, Inc
Claims Department