

TAXONOMY GUIDE

Taxonomy codes are 10-digit federally established numbers which health care providers use to identify their unique specialty areas. Ambetter by Peach State Health Plan providers are required to submit claims with the correct taxonomy code and qualifier consistent with the provider’s specialty to ensure appropriate claim adjudication. Peach State Health Plan will reject the claim if the taxonomy code is incorrect or omitted from the claim.

Taxonomy Code Example: 282N00000X

| TAXONOMY PLACEMENT ON A CLAIM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|-----|--|-------------------|------------|---------------|----------------|-----------|--------------------------|--|--------|--------------------|----|----|----|----|----|----|----|----|----|--|---------|------------------|-----|--|-------------------|------------|---------------|----------------|-----------|--------------------------|--|-------------------|--|--|--------------------|--|--|--|--|----|------------|--|--|--|--|--|--|--|--|--|-----|----------|--|---|--|--|---------|------------|--|----------|----------|
| CMS 1500 | <p>PAPER SUBMISSION:</p> <p>Rendering – Box 24i should contain the qualifier “ZZ.” Box 24j (shaded area) should contain the taxonomy code.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <th style="width: 10%;">24. A.</th> <th style="width: 15%;">DATE(S) OF SERVICE</th> <th style="width: 10%;">B.</th> <th style="width: 10%;">C.</th> <th style="width: 20%;">D.</th> <th style="width: 10%;">E.</th> <th style="width: 10%;">F.</th> <th style="width: 5%;">G.</th> <th style="width: 5%;">H.</th> <th style="width: 5%;">I.</th> <th style="width: 10%;">J.</th> </tr> <tr> <td></td> <td>From To</td> <td>PLACE OF SERVICE</td> <td>EMG</td> <td>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td> <td>DIAGNOSIS POINTER</td> <td>\$ CHARGES</td> <td>DAYS OR UNITS</td> <td>EPICDT From To</td> <td>ID. QUAL.</td> <td>RENDERING PROVIDER ID. #</td> </tr> <tr> <td></td> <td>MM DD YY MM DD YY</td> <td></td> <td></td> <td>CPT/HCPCS MODIFIER</td> <td></td> <td></td> <td></td> <td></td> <td>ZZ</td> <td style="background-color: #f0f0f0;">208U00000X</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td>REQUIRED</td> </tr> </table> <p>Billing – Box 33b should contain the qualifier “ZZ” along with the taxonomy code.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 30%; vertical-align: top;"> <p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p>SIGNED _____ DATE _____</p> </td> <td style="width: 30%; vertical-align: top;"> <p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI _____ b. _____</p> </td> <td style="width: 40%; vertical-align: top;"> <p>33. BILLING PROVIDER INFO & PH # ()</p> <p>a. REQUIRED _____ b. ZZ208U00000X</p> </td> </tr> </table> <p>Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code in the next column.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td> <td style="width: 10%;">17a. ZZ</td> <td style="width: 20%; background-color: #f0f0f0;">208U00000X</td> </tr> <tr> <td></td> <td>17b. NPI</td> <td>REQUIRED</td> </tr> </table> | | | | | | | | | | | 24. A. | DATE(S) OF SERVICE | B. | C. | D. | E. | F. | G. | H. | I. | J. | | From To | PLACE OF SERVICE | EMG | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | EPICDT From To | ID. QUAL. | RENDERING PROVIDER ID. # | | MM DD YY MM DD YY | | | CPT/HCPCS MODIFIER | | | | | ZZ | 208U00000X | | | | | | | | | | NPI | REQUIRED | <p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p>SIGNED _____ DATE _____</p> | <p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI _____ b. _____</p> | <p>33. BILLING PROVIDER INFO & PH # ()</p> <p>a. REQUIRED _____ b. ZZ208U00000X</p> | 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. ZZ | 208U00000X | | 17b. NPI | REQUIRED |
| 24. A. | DATE(S) OF SERVICE | B. | C. | D. | E. | F. | G. | H. | I. | J. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | From To | PLACE OF SERVICE | EMG | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | EPICDT From To | ID. QUAL. | RENDERING PROVIDER ID. # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | MM DD YY MM DD YY | | | CPT/HCPCS MODIFIER | | | | | ZZ | 208U00000X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | NPI | REQUIRED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. ZZ | 208U00000X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17b. NPI | REQUIRED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <p>ELECTRONIC SUBMISSION:</p> <p>Rendering – Loop 2310B PRV01 “PE” = Referring PRV02 = “ZZ” qualifier PRV03 = 10 character taxonomy code</p> <p>Billing – Loop 2000A-PRV01 “BI” PRV02 = “ZZ” qualifier PRV03 = 10 character taxonomy</p> <p>Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



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| UB-04 | PAPER SUBMISSION: Billing – Box 81CCa should contain the qualifier of “B3” in the left column and the taxonomy code in the middle column. | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"><tr><td>80 REMARKS</td><td>81CCa</td><td>B3</td><td>282N00000X</td><td></td><td></td></tr><tr><td></td><td>b</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>c</td><td></td><td></td><td></td><td></td></tr><tr><td></td><td>d</td><td></td><td></td><td></td><td></td></tr></table> | 80 REMARKS | 81CCa | B3 | 282N00000X | | | | b | | | | | | c | | | | | | d | | | |
| 80 REMARKS | 81CCa | B3 | 282N00000X | | | | | | | | | | | | | | | | | | | | | |
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| | c | | | | | | | | | | | | | | | | | | | | | | | |
| | d | | | | | | | | | | | | | | | | | | | | | | | |
| | ELECTRONIC SUBMISSION: Billing - Loop 2000A - PRV01 “BI” = “Billing”; PRV02 – “PXC” qualifier; PRV03 = 10 character taxonomy code | | | | | | | | | | | | | | | | | | | | | | | |

To learn more about Ambetter by Peach State Health Plan claim submission requirements, please visit the Ambetter provider website located at: <http://ambetter.pshpgeorgia.com/>.

For questions regarding this notice, please contact Provider Services at 1-877-687-1180.