Chapter 5: Billing on the CMS 1500 Claim Form

Introduction

The CMS 1500 claim form is used to bill for non-facility services, including professional services, freestanding surgery centers, transportation, durable medical equipment, ambulatory surgery centers and independent laboratories.

Successful CMS 1500 Claim Submission Tips

Format:

- Do not print, hand-write or stamp any extraneous data on the form.
- No hand-written corrections, no highlighting.
- Enter all information on the same horizontal plane within the designated field.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Use individual's name in provider signature, not a facility or practice name.

Accurate information is key:

- Put member's name and ID numbers as it appears on member card.
- Include all applicable NPI numbers.
- Indicate the correct address including ZIP code where service was rendered, making sure the address was reported to your Provider Services Representative and added to the Health Choice provider database.
- Ensure that the # of units/days and the dates of service range are not contradictory.
- Ensure that the quantity indicated in the procedure codes description are not contradictory.

Coding tips:

- Use current valid ICD -10 diagnosis codes and code them to the highest level of specificity (maximum number of digits) available.
- Primarydiagnosis
  - The primary diagnosis should describe the main condition or symptom of the patient.
  - For inpatient services, the primary diagnosis is the condition which was determined to be chiefly responsible for the inpatient stay, usually the discharge diagnosis.

Secondary/Additional Diagnosis

- This field should be used if there is a secondary and/or additional conditions or symptoms that affect the treatment.
- It is important that the secondary/additional diagnosis be indicated on inpatient stays when the length of stay or ancillary services have been affected.
- Diagnosis which relate to a previous illness and which have no bearing on the current encounter should not be reported.
- The number of anesthesia minutes should always be reported on each claim in Field 24G.

- Use current valid CPT and HCPCS codes.
- DMS-4 diagnosis codes, and behavioral health services are not covered.

Documentation Requirements

Providers must include all required documentation with the claim submission. Failure to do so may result in denial of the claim. Health Choice reserves the right to request additional documentation of the claim.

Completing the CMS 1500 Claim Form

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

1. Program Block -REQUIRED
   Check the last box labeled "HCIC" to bill for Health Choice Insurance Co. claim

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	HCIC. Co.
(Medicare#)	*(Medicaid#)*	*(Sponsor's SSN)*	☐ *(VA File #)*	☐ *(SSN or ID)*	*(SSN)*	☐ *(ID)*

1a. Insured's ID Number-REQUIRED
Enter the *members Health Insurance Co. ID number.* If there are questions about eligibility contact the Health Choice Member Services Department (See Chapter 2, Member Eligibility and Member Services). Behavioral health providers must be sure to enter the member's Health Choice Insurance Co. ID number, not the client's BHS number.

1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

2. Patient's Name-REQUIRED
   Enter member's last name, first name, and middle initial as shown on their ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Holliday, John H.

3. Patient's Date of Birth and Sex-REQUIRED

Enter the member's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE		
	SEX MM	DD
	YY	

8 14 1951 M F

4. Insured's Name –NOT REQUIRED

5. Patient Address –NOT REQUIRED

6. Patient Relationship to Insured–NOT REQUIRED

7. Insured's Address–NOT REQUIRED

8. Patient Status –NOT REQUIRED

9. Other Insured's Name-REQUIRED IF APPLICABLE

If the member has no coverage other than Health Choice Insurance Co. leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number-REQUIRED IF APPLICABLE

Enter the group number of the other insurance.

9b. Other Insured's Date of Birth and Sex-REQUIRED IF APPLICABLE

If the other insured is not the Health Choice member, enter the month, day, and year of the other insured's birth. Check the appropriate box to indicate gender.

9c. Employer's Name or School Name -REQUIRED IF APPLICABLE

Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

9d. Insurance Plan Name or Program Name -REQUIRED IF APPLICABLE

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Member's Condition Related to-REQUIRED IF APPLICABLE

Check "YES" or "NO" to indicate whether the member's condition is related to employment, an auto accident, or other accident. If the member's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

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 Group Policy or FECA Number-REQUIRED IF APPLICABLE

11a. Insured's Date of Birth and Sex-REQUIRED IF APPLICABLE

11b. Employer's Name or School Name-REQUIRED IF APPLICABLE

11c. Insurance Plan Name or Program Name-REQUIRED IF APPLICABLE

11d. Is There another Health Benefit Plan-REQUIRED IF APPLICABLE

Check the appropriate box to indicate coverage other than Health Choice. If "YES" is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature –NOT REQUIRED

13. Insured's or Authorized Person's Signature-NOT REQUIRED

14. Date of Illness or Injury- REQUIRED IF APPLICABLE

15. Date of Same or Similar Illness -NOT REQUIRED

16. Dates Patient Unable to Work in Current Occupation-NOT REQUIRED

17. Name of Referring Physician REQUIRED IF APPLICABLE

17a. ID number of Referring Physician is required for:

- Laboratory
- Radiology
- Medical and Surgical Supplies
- Respiratory DME
- Enteral and Parenteral Therapy
- Drugs (J-codes)
- Temporary K codes
- Orthotics
- Temporary Q codes
- Vision codes (V-codes)
- 97001-97546

Ordering providers can be a M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

17b. NPI # of Referring Provider-REQUIRED

18. Hospitalization Dates Related to Current Services-NOT REQUIRED

19. Reserved for Local Use-NOT REQUIRED

20. Outside Lab and ($) Charges-NOT REQUIRED

21. Diagnosis Codes –REQUIRED

Enter at least one *ICD-9 diagnosis code* describing the member's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to four diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. I 250. 52 Replace with and ICD 10　　　3. I_______ - ____________

2. I _______________ - __________　　　4. I _______ - ____________

22. Resubmission Code- REQUIRED IF APPLICABLE

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim.

See Chapter 7, General Billing Rules, for information on resubmission, adjustments, and voids.

23. Prior Authorization Number NOT REQUIRED

See Chapter 6, Authorization and Referrals, for information on prior authorization.

24A. Date of Service and NDC-REQUIRED/NDC IF APPLICABLE

- In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

24. A DATE(S) OF						B Place of	C	D PROCEDURE, SERVICES, OR (Explain Unusual	
From			To						
MM	DD	YY	MM	DD	YY	Servic	EMG	CPT/HCPCS	MODIFIE
N400074115278 ML10									
07	01	12	07	01	12	11		J1642	

The beginning and ending service dates must be entered in the non-shaded area.

24B. Place of Service-REQUIRED

Enter the two-digit code that describes the place of service.

03	School	23	ER-Hospital	53	Community Mental
04	Homeless Shelter	24	ASC	54	ICF/Mentally Retarded
05	HIS Free-Standing Facility	25	Birthing Center	55	Res. Substance Trtmt Fac.
06	HIS Provider-Based Facility	26	Military Treatment	56	Psych Residential Ctr
07	Tribal 638 Free Facility	31	Skilled Nursing Facility	57	Non-Residential Abuse Trtmt Facility
08	Tribal 638 Provider-based Facility	32	Nursing Facility	60	Mass Immunization

11	Office	33	Custodial Care Facility	61	Comp. IP Rehab Facility
12	Home	34	Hospice	62	Comp. Rehab Facility
13	Assisted Living	41	Ambulance-Land	65	ESRD Trtmt Facility
14	Group Home	42	Ambulance-Air	71	Public Health Clinic
15	Mobile Unit	49	Independent Clinic	72	Rural Health Clinic
19	Off Campus	50	FQHC	81	Independent
20	Urgent Care	51	Inpatient Psych Facility	99	Other
22	Outpatient Hospital-OP Hospital	52	Psych Facility-Partial Hosp.		

24. A		B	C	D	
DATE(S) OF SERVICE		Place of		PROCEDURE, SERVICES, OR SUPPLIES	
From	To		EMG	CPT/HCPCS	MODIFIE
		11			

24C. EMG -REQUIRED IF APPLICABLE

Mark this box with a “ ”, and “X”, or a “Y” if the service was an emergency service, regardless of where it was provided. (May want to consider using the new CMS 1500 form, it has more fields for ICD-10 and for modifiers.

24. A DATE(S) OF						B Place	C	D PROCEDURE, SERVICES, OR	
Fro			To			of		(Explain Unusual	
MM	DD	YY	MM	DD	YY	Servic	EMG	CPT/HCPCS	MODIFIE
							Y		

24D. Procedure and Procedure Modifier-REQUIRED

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service,* enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment. If more than two modifiers are required to completely delineate the service provided, enter “99” as the first modifier, then list the modifiers being billed with the procedure code. Call Claims Customer Service to verify that a modifier is valid for a procedure code.

24. A DATE(S) OF Fro MM DD YY	To MM DD YY	B Place of Servic	C Type of Servic	D PROCEDURE, SERVICES, OR (Explain Unusual CPT/HCPCS MODIFIER
				71010 26

24E. Diagnosis Pointer-REQUIRED

Relate the service provided to diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1,2,3 or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance. **To avoid claim denials, ensure the diagnosis code referenced in this field has a direct relationship to the CPT/HCPC code billed.**

D PROCEDURE, SERVICES, OR SUPPLIES		E	F	G	H
CPT/HCPCS	MODIFIER	DX CODE POINTER	CHARGES	DAYS OR UNITS	EPSDT Family Plan
		1			
		1, 2			

24F. Charges-REQUIRED

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D PROCEDURE, SERVICES, OR SUPPLIES		E	F	G	H
CPT/HCPCS	MODIFIER	DX CODE	CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150 00		
			79 00		

24G. Days or Units-REQUIRED

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D PROCEDURE, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E DX CODE	F CHARGES	G DAYS OR UNITS	H EPSDT Family Plan
				2	
				1	

24H. EPSDT/Family Planning-NOT REQUIRED

24I. ID Qualifier-REQUIRED IF APPLICABLE

24J. Rendering Provider ID Number-REQUIRED

(SHADED AREA) – Use for COB INFORMATION-REQUIRED IF APPLICABLE

Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a member's deductible has been met, enter zero (0) for the deductible amount.

For members and service covered by a third party payer, enter only the amount *paid.* Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement for Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied. See Chapter 14, Coordination of Benefits and Other Insurance Liability for details on billing claims with Medicare and other insurance.

24J. (NON SHADD AREA) – RENDERING PROVIDER ID #-REQUIRED

Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI number. The provider number is required I n24J if the NPI listed in 33A is not the same as the provider rendering services.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPST FAMILY PLAN	I ID QUAL	J RENDERING PROVIDER ID #
					COB Information
					NPI Rendering Provider NPI

25. Federal Tax ID-REQUIRED

    Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
		x	

26. Patient Account Number-REQUIRED IF APPLICABLE

    This is a number that the provider has assigned to uniquely identify this claim in the provider's records. Health Choice will report this number in correspondence, including the Remittance Advice.

27. Accept Assignment-NOT REQUIRED
28. Total Charge-REQUIRED

    Enter the total for all charges for all lines on the claim.

27. ACCEPT (For govt claims, see back) YES NO	28. TOTAL		29. AMOUNT	30. BALANCE
	$ 179	00	$	$

29. Amount Paid- REQUIRED IF APPLICABLE

    Enter the total amount that the provider has been paid for this claim by all sources *other than Health Choice.* Do *not* enter any amounts expected to be paid by Health Choice.

30. Balance Due-NOT REQUIRED
31. Signature and Date-REQUIRED

    The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initiated by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS. (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signed John Doe Date 3/01/16 (just updating this version)

32. Name and Address of Facility-REQUIRED IF APPLICABLE

    If the pay to address and the service address are the same, then box 32 is not required unless the rendering provider has multiple locations under the same TIN# then box 32 is required. Box 32 CANNOT contain a post office box address; it must be a physical address.

32. NAME AND ADRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

Arizona Hospital

123 Main Street

Scottsdale, AZ 85252

32A. NPI-REQUIRED IF APPLICABLE

If the service facility location is indicated, service facility NPI# must be entered.

32B. OTHER ID-NOT REQUIRED

33. Billing Provider Name, Address and Phone Number-REQUIRED
Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33A. Billing Provider NPI Number - REQUIRED

33. PHYSICAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

Doc Holliday

123 OK Corral Drive

Tombstone, AZ 85999

a. NPI b.

**Note – NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, box 33b must be completed.