CMS-1500 Claim Form

Introduction

Purpose

The purpose of this module is to provide an overview of the *CMS-1500* claim form. This module presents claim completion, processing instructions and offers participants general billing information required by the Medi-Cal program.

Module Objectives

Introduce general *CMS-1500* claim form billing guidelines

Identify field-by-field instructions for the completion and submission of the *CMS-1500* claim form

Discuss common claim form completion errors

Participate in an interactive claim completion learning activity

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

CMS-1500 Claim Form Description

The Health Insurance Claim form, *CMS-1500*, is used by Allied Health professionals, physicians, laboratories and pharmacies to bill for supplies and services provided to Medi-Cal recipients. Paper or electronic claim forms must be forwarded to the California Medicaid Management Information System (CA-MMIS) Fiscal Intermediary (FI) for processing within six months following the month in which services were rendered. Exceptions to the six-month billing limit can be made if the reason for the late billing is a delay reason allowed by regulations.

CMS-1500 Claim Form Completion Guidelines

Form Submission Methods

Paper Format

Providers are required to purchase *CMS-1500* (02/12) claim forms from a vendor. The claim forms ordered through vendors must include red “drop-out” ink to meet Centers for Medicare & Medicaid Services (CMS) standards. The following guidelines apply to claim forms submitted by mail:

Claim Submission Instructions

- Submit one claim form per set of attachments.
- Carbon or photocopies of computer-generated claim form facsimiles or claim forms created on laser printers are not acceptable.
- Do not staple original claims together. Stapling original claims together indicates the second claim is an “attachment”, not an original claim to be processed separately.
- Undersized attachments must be submitted on 8½ x 11-inch white paper using non-glare tape.
- All dates are entered without slashes. Do not use punctuation, such as decimal point (.) dollar sign ($), positive (+) or negative (-) symbol when entering amounts.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the California MMIS FI within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.

Full Reimbursement Policy

Table of Reimbursement Deadlines

If the Date of Service (DOS) falls within this month:	Then claims must be received by the last day of this month:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Partial Reimbursement Policy

Claims submitted after the six-month billing limit and received by the California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

- 100% Reimbursement from 0 to the end of 6 months.
- 75% Reimbursement from 7 months to the end of 9 months.
- 50% Reimbursement from 10 months to the end of a year.

Delay Reason Codes

Claims can be billed beyond the six-month billing limit if a delay reason code is used. The delay reason code indicates that the claim form is being submitted after the six-month billing limit.

Although a delay reason code designates approved reason for late claim submission, these exceptions also have time limits. For a complete description of the Delay Reason Codes refer to the *CMS-1500 Submission and Timeliness Instructions* section (cms sub) of the Part 2 provider manual.

Table of Delay Reason Codes

Delay Reason Code	Description
1	Proof of Eligibility (POE) unknown or unavailable
3	TAR approval delays
4	Delay by DHCS in certifying providers
5	Delay in supplying billing forms
6	Delay in delivery of custom-made eye appliances
7	Third party processing delay
10	Administrative delay in prior approval process
11	Other (eg. theft); attach documentation justifying delay reason
15	Natural disaster

Note: To receive full payment, providers must attach documentation justifying the delay reason. Providers billing with a delay reason code without the required attachments will be denied or reimbursed at a reduced rate.

Billing Notice: Most providers may no longer bill Medi-Cal or CCS using a recipient's Social Security Number (SSN). Claims submitted with a recipient's SSN will be denied.

CMS-1500 Delay Reason Code Claim Example

For the *CMS-1500* form, enter a delay reason code in the unshaded area of the *EMG* field (Box 24C) when the claim is beyond the six-month billing limit. If an emergency code is listed in the unshaded area, place the delay reason code in the shaded area.

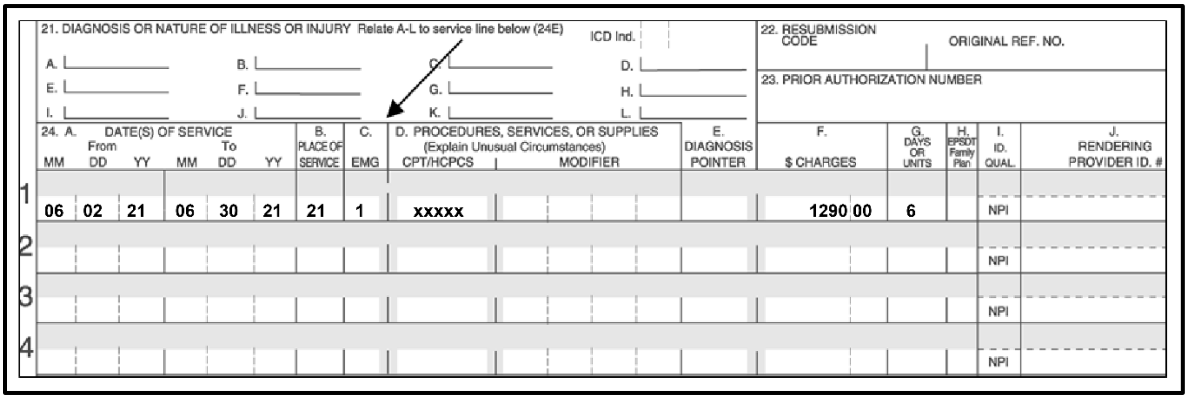


Figure 1: EMG Field on the *CMS-1500* Form

Claims Beyond One Year

Occasionally, a claim may be delayed more than one year past the date of service. The following is a list of possible scenarios that could result in a claim being submitted beyond one year:

- Third party decisions or appeals
- Determination of Medi-Cal eligibility
- *Treatment Authorization Request* (TAR) approval delay

Providers may still be eligible to receive 100 percent reimbursement of the Medi-Cal maximum allowable rate. Claims submitted more than 12 months after the month of service must use delay reason code 10. These claims must be billed hard copy and with appropriate attachments. Providers can send late claims to the California MMIS Fiscal Intermediary at the following address:

Attn: Over One Year Claims Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

Note:

- Claims and attachments more than a year old may not be submitted electronically
- Claims more than a year old will not receive an acknowledgement or response letter.
- Providers will receive a RAD message indicating the status of their claim.

Refer to the appropriate Part 2 provider manual section: *CMS-1500: Submission and Timeliness Instructions* (cms sub).

Form Completion Instructions

- Handwritten claims should be printed neatly using black ballpoint pen ONLY. Do not use red pencils or red ink ballpoint pens.
- Type all information using capital letters and 10-point font-size or larger for clarity and accuracy.
- Punctuation or symbols ($, %, &, /, etc.) should only be used in designated areas.
- Type only in areas of the form designated as fields. Data must fall completely within the text space and should be properly aligned.
- Do not use highlighters or correction tapes/fluid on hard copy claim forms or follow-up forms.
- Verify that claim form information is valid and appropriate for the services rendered for the date of service before mailing:
  - Procedure code
  - Modifier (if appropriate)
  - Place of service
  - Inclusion of ICD indicator

Mailing Information

- Mail *CMS-1500* claim forms to the FI in the blue and white, color-coded envelopes.
- Envelopes are free of charge. Order envelops by calling the Telephone Service Center (TSC) at 1-800-541-5555.
- Do not fold or crease claim forms to fit into small-sized envelopes.

Electronic Transmission

Computer Media Claims (CMC) submission is the most efficient method for billing Medi-Cal. CMC submission offers additional efficiency to providers because these claims are submitted faster and entered into the claims processing system faster.

The ICD version qualifier will be entered in the HI – Health Care Diagnosis Code segment. For Principal Diagnosis, providers enter “ABK” to indicate that ICD-10-CM diagnosis codes were entered on the claim.

Claim Submission Instructions

The following guidelines apply to claims submitted by electronic transmission:

- Claims may be submitted electronically via CMC telecommunications (modem) or the Medi-Cal website (*www.medi-cal.ca.gov*).
- A *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153) must be on file with the FI.
- Claims requiring hard copy attachments may be billed electronically, but only if the attachments are submitted according to the instructions for Attachment Control Forms, as described below.
- Attachment Control Forms must be accompanied by a Medi-Cal claim *Attachment Control Form* (ACF) and mailed or faxed to the FI. The attachments must be completed as specified or the attachments will not be linked with the electronic claim, resulting in claim denial.

Billing Instructions

Electronic data specifications and billing instructions are located in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual.*

Contact Information

For additional information, contact TSC at 1-800-541-5555.

Notes:

Additional Forms (Attachments)

Medi-Cal Claim Attachment Control Form (ACF)

An ACF validates the process of linking paper attachments to electronic claims. Under HIPAA rules, an 837 v.5010 electronic claim cannot be rejected (denied) because it requires an attachment. The California Medicaid Management Information System (CA-MMIS) processes paper attachments submitted in conjunction with an (837 v.5010) electronic claim.

For each electronically submitted claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Providers will be required to use the 11-digit Attachment Control Number (ACN) from the ACF to populate the Paperwork (PWK) segment of the 837 HIPAA transactions.

Attachments must be mailed or faxed to the FI at the following address or fax number:

California MMIS Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852
Fax: 1-866-438-9377

Note: The method of transmission (mail or fax) must be indicated in the appropriate PWK segment and must match the method of transmission used.

Attachment Policies

The following guidelines apply to attachments submitted with a *CMS-1500* claim form:

- All attachments must be received within 30 days of the electronic claim submission.
- Paper attachments cannot be matched after 30 calendar days.
- To ensure accurate processing, only one ACN value will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.

Denied Claim Reasons

- If an 837 v.5010 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If there is no ACF received by the FI, the attachments or documentation will be returned with a rejection letter to the provider or submitter.
- No photocopies of the ACF will be accepted.
- The method of transmission must match the method of transmission indicated in the PWK segment; otherwise, the attachment will not link up with the claim and it will be denied for no attachment received.

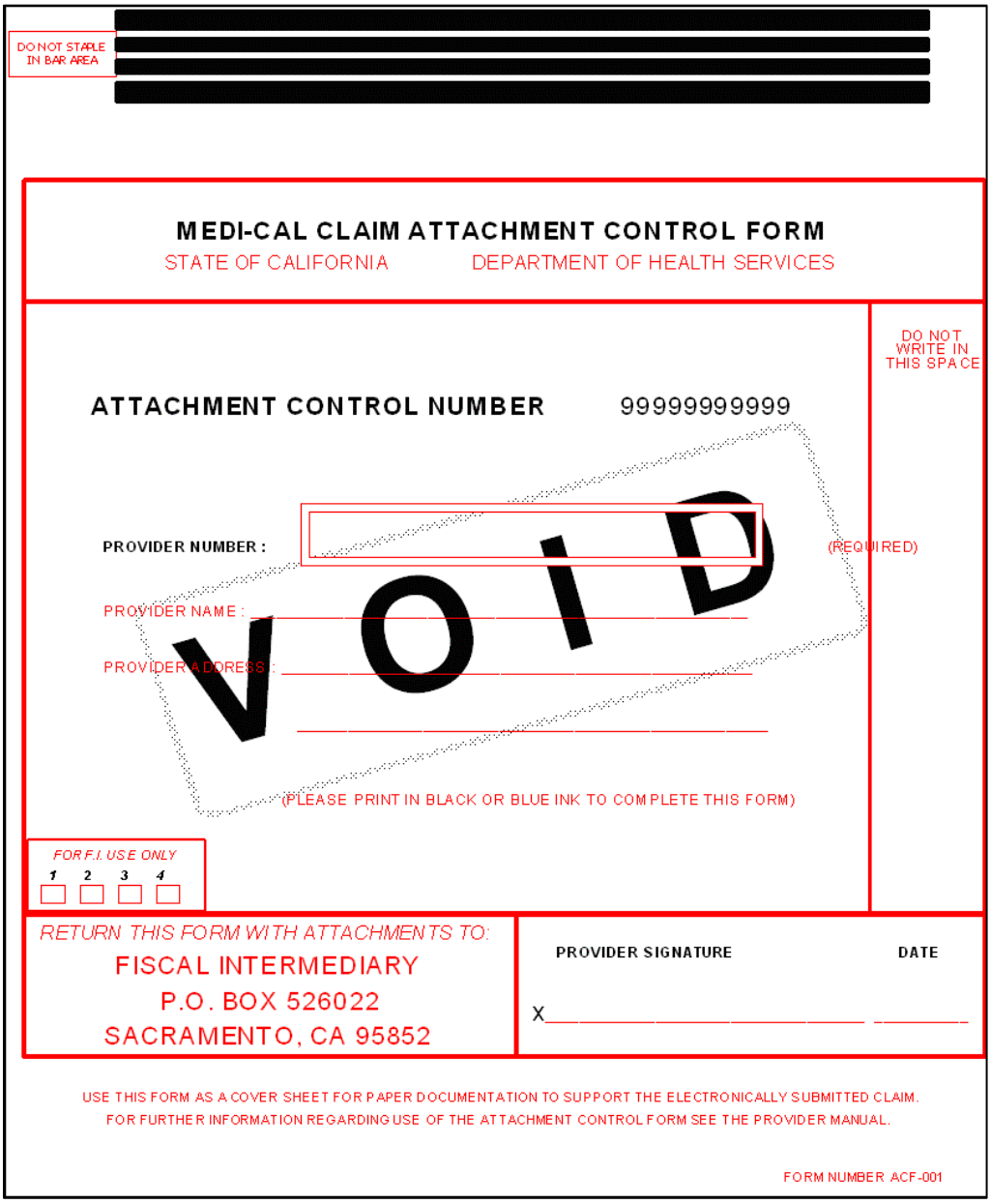
ACF Order/Reorder Instructions

To order ACFs, follow the instructions below:

- Call TSC at 1-800-541-5555; or
- Complete and mail the hard copy reorder form.

For further instructions, refer to *the Forms Reorder Request: Guidelines* section (forms reo) of the Part 2 provider manual or visit the Medi-Cal website (*www.medi-cal.ca.gov*).

Note: ACFs and envelopes are provided free of charge to all providers submitting 837 v.5010 electronic transactions.



Sample ACF

California MMIS
Fiscal Intermediary

P.O. Box 13029
Sacramento, CA 95813-4029

1.800.541.5555

Date:

ATTACHMENT CONTROL FORM REJECT LETTER

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

_____ **Invalid ACF**
(Only original ACFs provided by California Department of Health Care Services (DHCS) will be accepted)

_____ **Missing ACF**
(Paper attachments submitted without ACF)

_____ **Supporting documentation missing**
(ACF received without paper attachments)

_____ **Invalid Attachment Control Number (ACN) on ACF**
(Pre-imprinted CANNOT be altered or unreadable)

_____ **Other:** _____

Please resubmit your electronic claim if:

The resubmitted ACF has an Attachment Control Number (ACN) that differs from your original electronic claim form or;

More than 30 days have passed since you originally submitted your electronic claim.

Mail attachments to: California MMIS Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center (TSC) at 1-800-541-5555.

Sincerely,

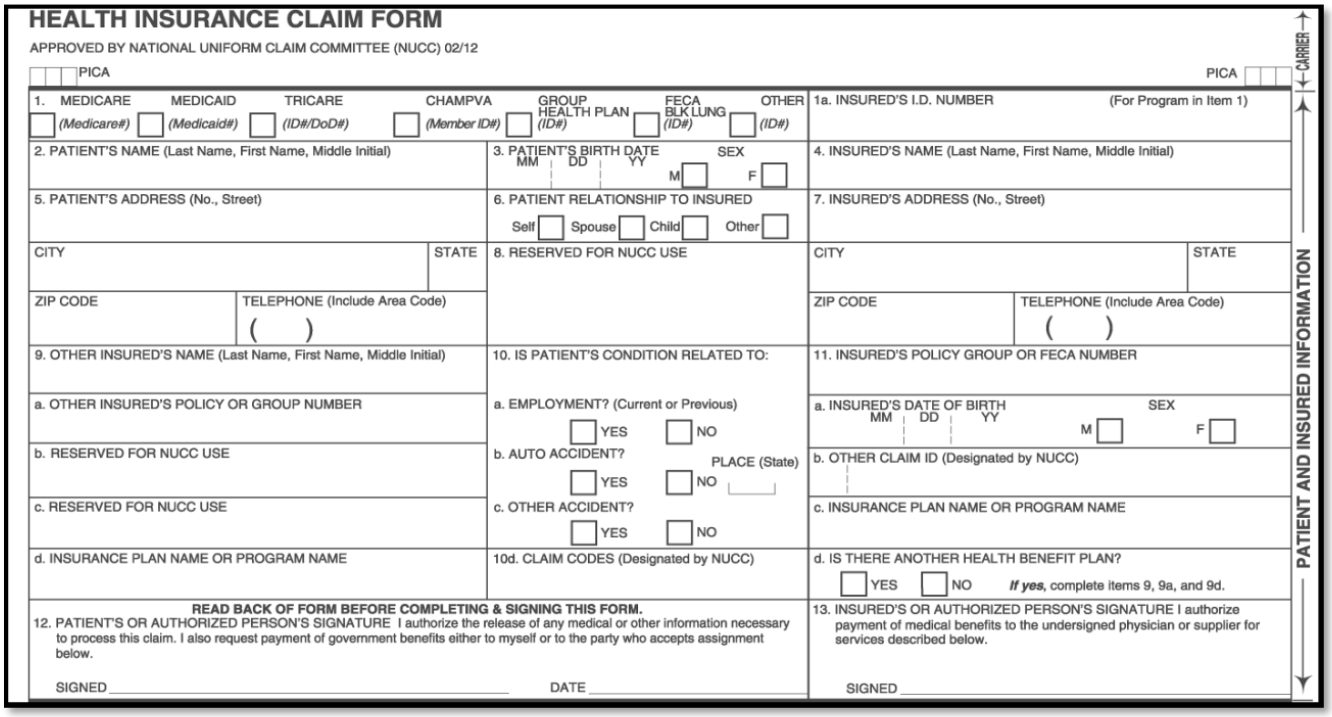
California Medicaid Management Information System Fiscal Intermediary

Sample: ACF Rejection Letter

CMS-1500 Claim Form Completion

CMS-1500 Claim Form **(Fields 1 thru 13)**

The *CMS-1500* claim form is a national form; therefore, many fields are not required by Medi-Cal. Field-by-field instructions for completing the *CMS-1500* claim form are in the *CMS-1500 Completion* section (cms comp) of the appropriate Part 2 provider manual.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

CARRIER

PATIENT AND INSURED INFORMATION

Sample: Partial *CMS-1500* Claim Form

Notes:

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Table of Field Descriptions for the CMS-1500 Claim Form

Box #	Field Name	Instructions	Billing Tip
1	Medicaid/ Medicare/ Other Id	For Medi-Cal, enter an "X" in the *Medicaid* box.	When billing Medicare crossover claims, check both the Medicaid and Medicare boxes.
1A	Insured's ID Number	Enter the recipient's ID number from the Benefits Identification Card (BIC). Do not enter the Medicare ID number unless it is a crossover. When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field.	Use the POS Network to verify that the recipient is eligible for the services rendered.
2	Patient's Name	Enter the recipient's last name, first name and middle initial (if known). Avoid nicknames or aliases. *A comma is required between recipient's last name, first name and middle initial (if known).*	**Newborn Infant:** When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 2. If the infant has not been named, write the mother's last name followed by BABY BOY or BABY GIRL.
3	Patient's Birth Date/Sex	Enter the recipient's date of birth in six-digit MMDDYY format (month, day, year). If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth in Box 19. Enter an "X" in the M or F box.	**Newborn Infant:** Enter the infant's sex and date of birth in Box 3.
4	Insured's Name	*Not required by Medi-Cal,* except when billing for a newborn using the mother's ID. Enter the mother's name in this field when billing for the newborn.	**Newborn Infant:** Enter the mother's name in the Insured's Name field (Box 4).
5	Patient's Address and Telephone	Enter the recipient's complete address and telephone number.	None.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

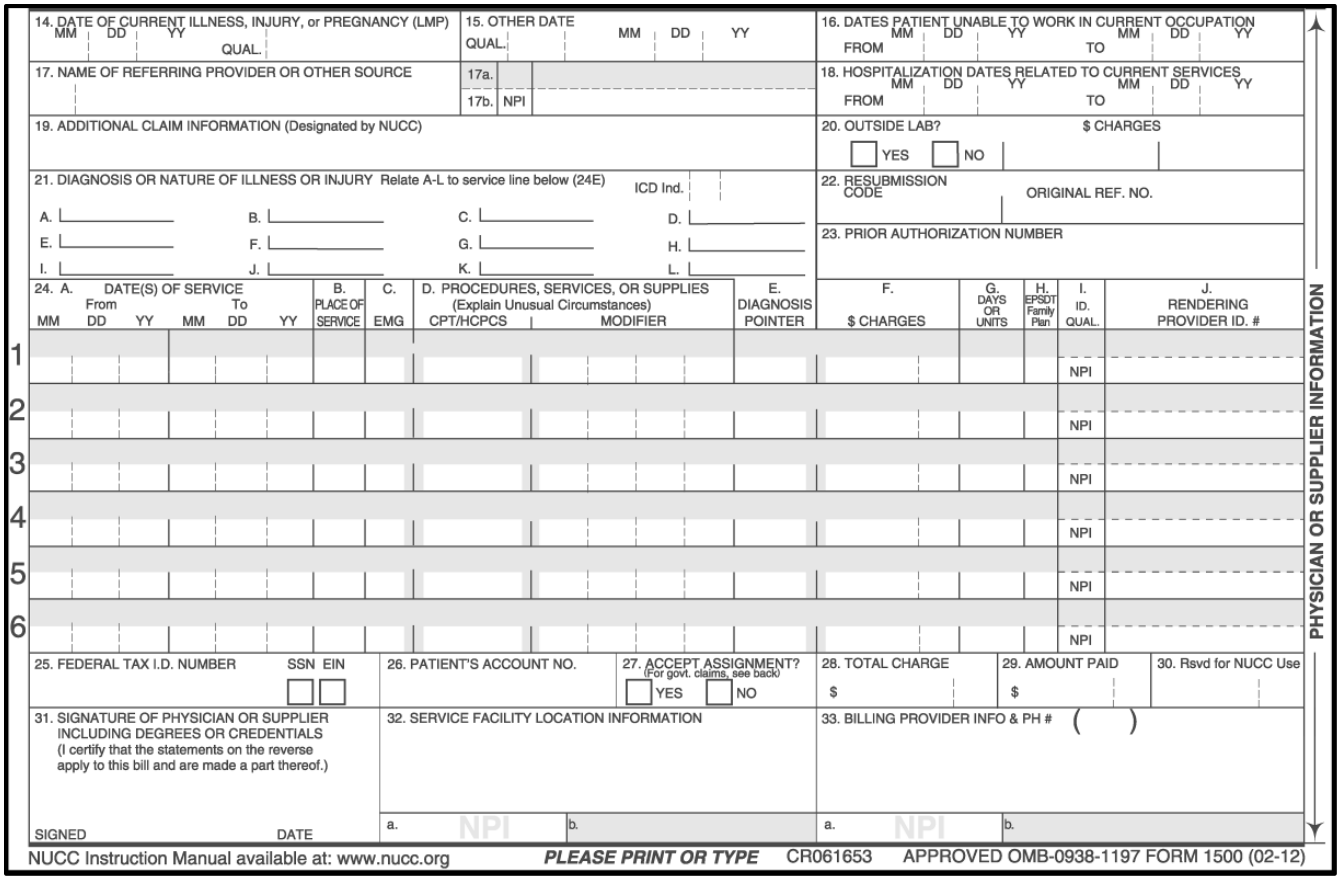
Box #	Field Name	Instructions	Billing Tip
6	Patient's Relationship to Insured	*Not required by Medi-Cal.* This field should be used when billing for an infant using the mother's ID by checking the *Child* box.	None
10A	Employment	Complete this field if services were related to an accident or injury. • Enter an "X" in the Yes box if accident/injury is employment related. • Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the *Date of Current Illness, Injury or Pregnancy* field (Box 14).	None
10D	Claim Codes (Designated by NUCC)	Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign ($). Enter the full dollar amount including cents, even if the amount ends in zeros (e.g. if SOC collected/obligated is $100, enter 10000, not 100).	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
11D	Another Health Benefit Plan	Enter an "X" in the Yes box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar or decimal point) by the other health insurance in the right side of Box 11D.	Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal. Eligibility under Medicare or Medi-Cal Managed Care Plan (MCP) is not considered OHC.

Notes:

CMS-1500 Claim Form **(Fields 14 thru 33)**



Sample: Partial *CMS-1500* Claim Form

Notes:

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Table of Field Descriptions for the CMS-1500 Claim Form

Box #	Field Name	Instructions	Billing Tip
14	Date of Current Illness, Injury or Pregnancy (LMP)	Enter the date of the onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP). Medi-Cal does not require a qualifier (QUAL) in this field.	None.
17	Name of Referring Provider or Other Source	Must indent text two bytes. Enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the NMP must be entered. The NPI of the supervising physician needs to be entered in box 17B, below. **Note:** Provider's billing lab services for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A as the referring provider.	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
17B	NPI (Of Referring Physician)	Enter the 10-digit NPI. The following providers must complete Box 17 and Box 17B: • Audiologist • Clinical laboratory (services billed by laboratory) • Durable Medical Equipment (DME) and medical supply • Hearing aid dispenser • Nurse anesthetist • Occupational therapist • Orthotist • Pharmacist • Physical therapist • Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B) • Portable imaging services • Prosthetist • Radiologist • Speech pathologist	None
18	Hospitalization Dates Related to Current Services	Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
19	Additional Claim Information (Designated by NUCC)	Use this area for procedures that require additional information, justification or an *Emergency Certification Statement.*	"By Report" codes, complicated procedures, unlisted services and anesthesia time require attachments. Box 19 may be used if space permits. **Please do not staple attachments.**
20	Outside Lab?	If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." "Outside laboratory" refers to a lab not affiliated with the billing provider. Indicate in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank, if not applicable.	None
21	Diagnosis or Nature of Illness or Injury Relate A thru L to service line below (24E)	Claims with a diagnosis code must include the ICD indicator "0". Medi-Cal requires providers to enter the ICD indicator "0". **Note:** Claims submitted without a diagnosis code do not require an ICD indicator.	None
21A	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers of the ICD-10-CM diagnosis code for the primary diagnosis, including fourth through seventh characters, if present. (Do not enter decimal point). The following services are exempt from diagnosis descriptions and codes when they are the only services billed on the claim: 1. Anesthesia services 2. Assistant surgeon services 3. Medical supplies 4. Medical transportation 5. Pathology services 6. Radiology services (exceptions: CAT scan, nuclear medicine, ultrasound, radiation therapy and portable imaging services).	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
21B	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM diagnosis code, including fourth through seventh characters, if present. (Do not enter decimal point.)	None
21C thru L	Diagnosis or Nature of Illness or Injury	Not required by Medi-Cal. Medi-Cal only accepts two diagnosis codes. Codes entered in Boxes 21.C thru L will not be used for claims processing.	None
22	Resubmission Code	Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.	None
23	Prior Authorization Number	Physician and podiatry services requiring a *Treatment Authorization Request* (TAR) must enter the 11-digit TAR Control Number (TCN). For California Children's Services (CCS) claims, enter the 11-digit Service Authorization Request (SAR) number. It is not necessary to attach a copy of the TAR to the claim. **Note:** TAR and non-TAR procedures should not be combined on the same claim.	Recipient information on the claim must match the TAR/SAR. Only one TCN can cover the services billed on any one claim.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24A	Date(s) of Service	Enter the date the service was rendered in the From and To boxes in the six-digit, MMDDYY (month, day, year) format in the unshaded area. When billing for a single date of service, enter the date in *From* box in Field 24A. **National Drug Code (NDC) for Physician Administered Drugs:** In the shaded area, enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). **Universal Product Number (UPN) for contracted disposable incontinence and medical supplies:** In the shaded area, enter the appropriate UPN qualifier followed by the UPN. Refer to the *Physician-Administered Drugs – NDC: CMC-1500 Billing Instructions* section (physician ndc cms) in the Part 2 provider manual.	None
24B	Place of Service	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered.	The national Place of Service codes are listed in the *CMS-1500 Completion* section (cms comp) in the Part 2 provider manual.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24C	EMG	Emergency or Delay Reason Codes. **Delay Reason Code**: If there is no emergency indicator in Box 24C, enter a delay reason code in the unshaded portion of the box. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim. **Emergency Code:** Enter an "X" when billing for emergency services, or the claim may be reduced or denied. Only one emergency indicator is allowed per claim, and must be placed in the unshaded, bottom portion of Box 24C. An Emergency Certification Statement is required for all services rendered under emergency conditions. The statements must be signed and dated by the provider and must describe the nature of the emergency including clinical information about the patient's condition. A mere statement that an emergency occurred is not sufficient. The Emergency Certification Statement may be attached to the claim or entered in Box 19 "Additional Claim Information" field.	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24D	Procedures, Services or Supplies/ Modifier	Enter the appropriate procedure code (CPT or HCPCS) and modifier(s).	The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple National Correct Coding Initiative (NCCI)-associated modifiers on the same claim line. If necessary, the procedure description can be entered in the *Additional Claim Information* field (Box 19). Do not submit a National Correct Coding Initiative (NCCI)-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted.
24E	Diagnosis Pointer	As required by Medi-Cal.	

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24F	$ Charges	In the unshaded area of the form, enter the usual and customary fee for service(s) in full dollar amount. Do not enter a decimal point (.) or dollar sign ($). For example, $100 should be entered as “10000.” If an item is a taxable medical supply, include the applicable state and county sales tax.	None
24G	Days or Units	Enter the number of medical “visits” or procedures, surgical “lesions,” hours of “detention time,” units of anesthesia time, items or units of service, etc. The field permits entries up to 999 in the unshaded area. For entries greater than 999, carry the remaining value to the next claim line.	Providers billing for units of time should enter the time in 15-min increments. For example, one hour should be entered as “4.”
24H	EPSDT Family Plan	Enter code “1” or “2” if the services rendered are related to family planning (FP). Enter code “3” if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.	Refer to the *Family Planning* section (fam planning) of the appropriate Part 2 provider manual for additional details.
24J	Rendering Provider ID #	Enter the NPI for a rendering provider (unshaded area) if the provider is billing under a group NPI. If the provider is not billing under a group NPI, leave this field blank in order for claims to be reimbursed correctly. This applies to all services.	If an error has been made to specific billing information entered on items 24A thru 24J, draw a line through the entire detail using a black ballpoint pen. Enter the <u>correct</u> billing information on another line. Do not black out the entire claim line. Deleted information may be used to determine previous payment

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

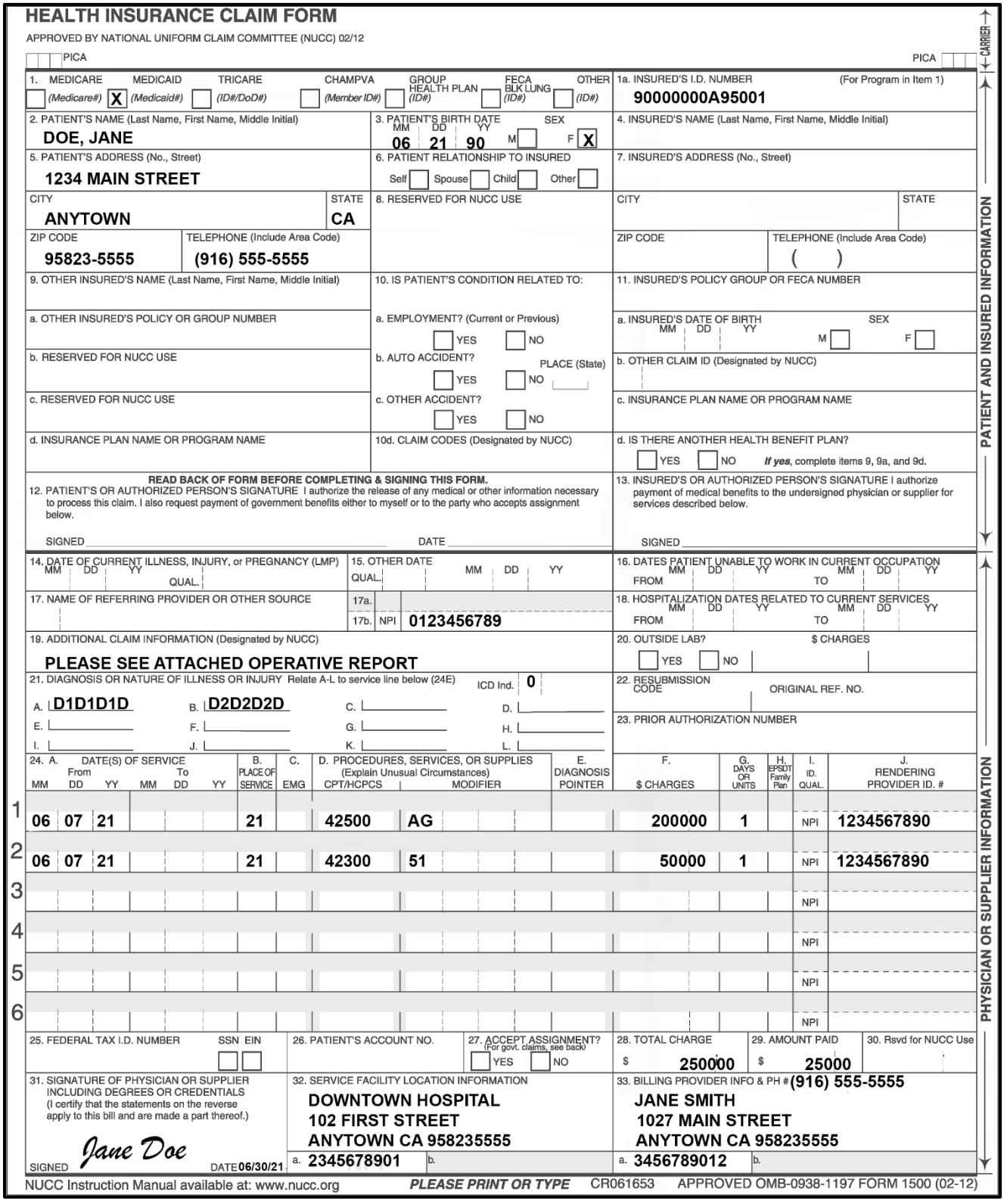
Box #	Field Name	Instructions	Billing Tip
28	Total Charge	Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as “10000.”	None
29	Amount Paid	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient’s Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($).	Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare EOMB/MRN/RA when submitted with the claim
30	Rsvd for NUCC Use	Effective for dates of service on or after October 1, 2014, this box is no longer required to be completed.	None
31	Signature of Physician or Supplier…	The claim must be signed and dated by the provider or a representative assigned by the provider, in black ballpoint pen only.	An original signature is required on all paper claims. The signature must be written, not printed and should not extend outside the box. Stamps, initials or facsimiles are not accepted.
32	Service Facility Location Information	Enter the provider name. Enter the provider’s address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen.	Use the name and address of the facility where the services were rendered if other than a home or office. **Note:** Not required for clinical laboratories when billing for their own services.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
32A	(blank)	Enter the NPI of the facility where the services were rendered.	None
32B	(blank)	Enter the Medi-Cal provider number for an atypical service facility.	None
33	Billing Provider Info and Phone Number	Enter the provider name. Enter the provider address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. Enter the telephone number. **Note:** The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.	None
33A	(blank)	Enter the billing provider's NPI.	
33B	(blank)	Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.	Do not submit claims using a Medicare provider number or state license number. Claims from providers and/or billing services that consistently bill numbers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.

D CMS-1500 Claim Form

Page updated: January 2022



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 90 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 95823-5555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PLEASE SEE ATTACHED OPERATIVE REPORT

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 07 21		21		42500	AG		200000	1		NPI	1234567890
2 06 07 21		21		42300	51		50000	1		NPI	1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 250000

29. AMOUNT PAID $ 25000

30. Rsvd for NUCC Use

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.)

SIGNED Jane Doe DATE 06/30/21

32. SERVICE FACILITY LOCATION INFORMATION

DOWNTOWN HOSPITAL
102 FIRST STREET
ANYTOWN CA 958235555

a. 2345678901 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 3456789012 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

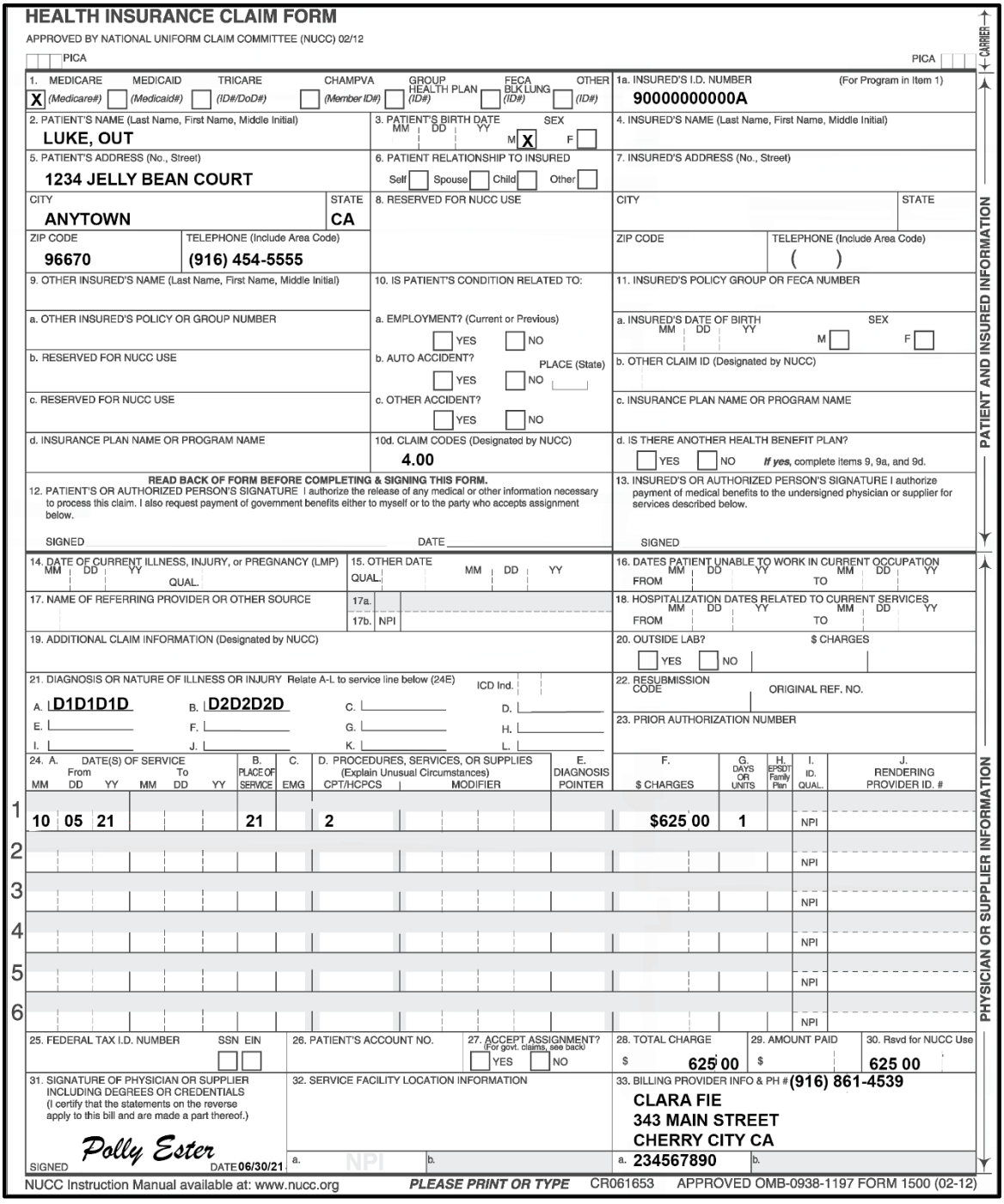
PHYSICIAN OR SUPPLIER INFORMATION

Sample: *CMS-1500* Claim Form

Learning Activity

What is wrong with this claim?

Identify 15 claim completion errors. See the Appendix for the Answer Key.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000000A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LUKE, OUT

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 JELLY BEAN COURT

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN | STATE: CA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 96670 | TELEPHONE (Include Area Code): (916) 454-5555

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): 4.00

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. D1D1D1D B. D2D2D2D C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	05	21			21		2			$625 00	1		NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 625 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use 625 00

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.)

Polly Ester

SIGNED DATE 06/30/21

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 861-4539

CLARA FIE
343 MAIN STREET
CHERRY CITY CA

a. 234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

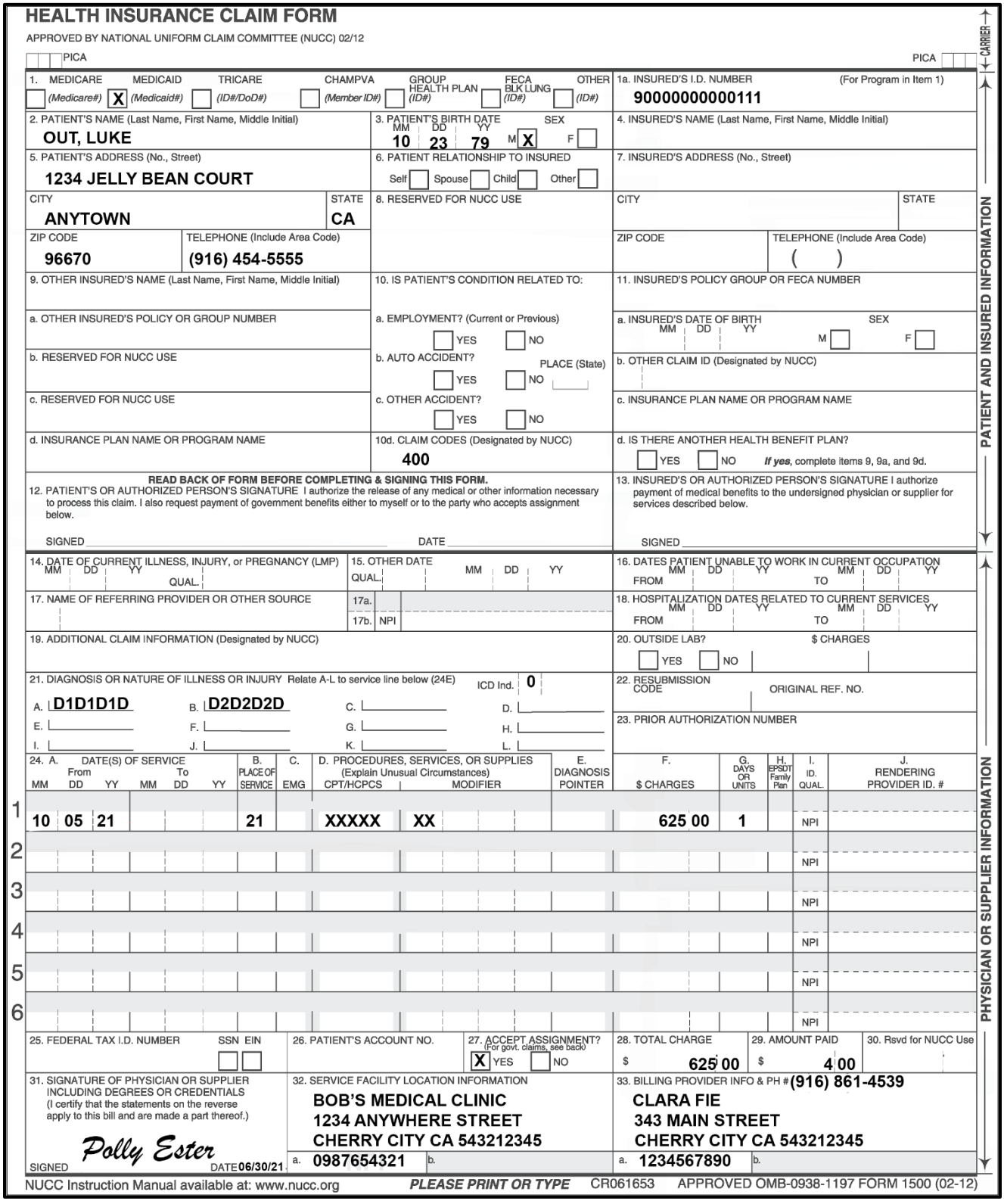
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample: Incorrect *CMS-1500* Claim Form

D CMS-1500 Claim Form

Page updated: January 2022



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000000111

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): OUT, LUKE

3. PATIENT'S BIRTH DATE: 10 23 79 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 JELLY BEAN COURT

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN | STATE: CA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 96670 | TELEPHONE (Include Area Code): (916) 454-5555

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): 400

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 05 21		21		XXXXX	XX		625 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 625 00

29. AMOUNT PAID $ 4 00

30. Rsvd for NUCC Use

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.)

SIGNED Polly Ester DATE 06/30/21

32. SERVICE FACILITY LOCATION INFORMATION

BOB'S MEDICAL CLINIC
1234 ANYWHERE STREET
CHERRY CITY CA 543212345

a. 0987654321 b.

33. BILLING PROVIDER INFO & PH # (916) 861-4539

CLARA FIE
343 MAIN STREET
CHERRY CITY CA 543212345

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample: Corrected *CMS-1500* Claim Form

Resource Information

Provider Manual References

Part 1

CMC Enrollment Procedures (cmc enroll)
Computer Media Claims (cmc)

Part 2

CMS-1500 Completion (cms comp)
CMS-1500 Special Billing Instructions (cms spec)
CMS-1500 Submission and Timeliness Instructions (cms sub)
CMS-1500 Tips for Billing (cms tips)