
CMS-1500 Completion

Page updated: February 2025

The Health Insurance Claim Form (CMS-1500) is used by Allied Health professionals, physicians, laboratories and pharmacies to bill supplies and services to the Medi-Cal program. Providers are required to purchase *CMS-1500* claim forms from a vendor. Claim forms ordered through vendors must include red “drop-out” ink.

«Most claims for these services and supplies may also be submitted through ASC X12N 837 v. 5010 claim on the Medi-Cal Provider Portal. For 837 claims information, refer to the *Electronic Data Interchange (EDI) 837 Claims Overview* section in the Part 1 manual.»

For additional billing information, refer to the *CMS-1500 Special Billing Instructions*, *CMS-1500 Submission and Timeliness Instructions* and the *CMS-1500 Tips for Billing* sections in this manual.

Medicare/Medi-Cal Billing for Medical Supplies

Medicare covers certain medical supplies, listed in the *Medical Supplies: Medicare Covered Services* section of the appropriate Part 2 manual. Providers must bill Medicare prior to billing Medi-Cal for these medical supplies. Most Medicare-approved claims will cross over to Medi-Cal automatically. However, if for some reason this does not occur, providers must bill Medicare-covered medical supplies to Medi-Cal as crossover claims on the *CMS-1500* claim form with proof of Medicare billing attached. (Medi-Cal does not accept direct-to-Medi-Cal crossover claims from providers electronically. Providers must submit these claims on paper).

For more detailed crossover billing information, refer to the appropriate *Medicare/Medi-Cal Crossover Claims* section in this manual.

Durable Medical Equipment (DME)

Pharmacies that dispense Durable Medical Equipment (DME) or orthotic or prosthetic devices must bill for them on the *CMS-1500* and must be enrolled in the proper category of service with the Department of Health Care Services (DHCS), Provider Enrollment Division (PED).

«Pharmacies billing on the *CMS-1500* may also bill DME using the Medical Record (Claim Type 5) or the ASC X12N 837 Professional v.5010 (837P).» Pharmacies billing DME electronically are subject to the enrollment requirements specified above.

Blood

Pharmacies billing for blood derivatives and cryoprecipitates (frozen blood) must bill on the *CMS-1500*.

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (For Program in Item 1)							
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)				MEDI-CAL ID NUMBER							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
PATIENT'S LAST NAME, FIRST NAME						MM DD YY			MOTHER'S NAME FOR NEWBORN		
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)		
PATIENT'S COMPLETE ADDRESS						Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY				STATE		CITY				STATE	
PATIENT'S CITY				ST							
ZIP CODE		TELEPHONE (Include Area Code)				ZIP CODE		TELEPHONE (Include Area Code)			
PATIENT'S 9-DIGIT ZIP		(PATIENT'S PHONE)			
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)			a. INSURED'S DATE OF BIRTH		
b. RESERVED FOR NUCC USE						<input type="checkbox"/> YES <input type="checkbox"/> NO			MM DD YY		
c. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State)			M <input type="checkbox"/> F <input type="checkbox"/>		
d. INSURANCE PLAN NAME OR PROGRAM NAME						c. OTHER ACCIDENT?			b. OTHER CLAIM ID (Designated by NUCC)		
						<input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME		
						10d. CLAIM CODES (Designated by NUCC)			MEDICARE CARRIER CODE		
									d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
									<input type="checkbox"/> YES <input type="checkbox"/> NO		
									OTHER COVERAGE/AMOUNT		
									If yes, complete items 9, 9a, and 9c.		
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.						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		
SIGNED NA						DATE NA					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)						15. OTHER DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		
MM DD YY						MM DD YY			FROM MM DD YY TO MM DD YY		
ONSET DATE									FROM NA TO NA		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
NAME OF REFERRING PROVIDER						17b. NPI NPI			FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES					
ADDITIONAL JUSTIFICATION PLACED HERE						<input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.						22. RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER		
A. [DIAGNOSIS CODE 1] B. [DIAGNOSIS CODE 2] C. [DIAGNOSIS CODE 3] D. [DIAGNOSIS CODE 4]						RESUBMIT CODE					
E. [DIAGNOSIS CODE 5] F. [DIAGNOSIS CODE 6] G. [DIAGNOSIS CODE 7] H. [DIAGNOSIS CODE 8]									TAR CONTROL NUMBER		
I. [DIAGNOSIS CODE 9] J. [DIAGNOSIS CODE 10] K. [DIAGNOSIS CODE 11] L. [DIAGNOSIS CODE 12]											
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLIES		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS		F. \$ CHARGES	
From To		EMG		(Explain Unusual Circumstances)		CPT/HCPCS MODIFIER		DIAGNOSIS POINTER		G. DAYS OR UNITS	
MM DD YY MM DD YY										H. EP/SDT Family Plan	
QUALIFIER + NDC OR UPN		UNIT QUALIFIER AND QUANTITY								I. ID. QUAL.	
DOS FROM DOS THRU POS		PROC CODE MODIFIERS								J. RENDERING PROVIDER ID. #	
1										NON-NPI NUMBER	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NUMBER		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO		28. TOTAL CHARGE \$TOTAL CHARGES		29. AMOUNT PAID TOTAL DEDUCTIONS	
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # (PHONE NUMBER)			
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED				NAME AND ADDRESS OF SERVICE FACILITY				BILLER ADDRESS			
SIGNED DATE DATE				a. FACILITY NPI		b. NON-NPI NUMBER		a. BILLER NPI		b. NON-NPI NUMBER	

Figure 1: CMS-1500 Medi-Cal-Required Fields.

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *CMS-1500* on the previous page and are unique to Medi-Cal. All items must be completed unless otherwise noted in these instructions.

Note: Items described as “Not required by Medi-Cal” (NA) may be completed for other payers but are not recognized by the Medi-Cal claims processing system.

Undesignated White Space. Do not type in the top one inch of the *CMS-1500* claim form, because this area is reserved for fiscal intermediary use.

Explanation of Form Items Table

Item	Description
1	<p>Medicaid/Medicare/Other ID. If the claim is a Medi-Cal claim, enter an “X” in the Medicaid box. If submitting a Medicare/Medi-Cal crossover claim, use a copy of the original <i>CMS-1500</i> billed to Medicare and enter an “X” in both the <i>Medicaid</i> and <i>Medicare</i> boxes</p> <p>Note: For more information about crossover claims, refer to the <i>Medicare/Medi-Cal Crossover Claims: CMS-1500</i> section in the appropriate Part 2 manual</p>
1a	<p>Insured’s ID Number. «Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC), paper Medi-Cal ID card or Medi-Cal Eligibility Confirmation Letter.»</p>

Newborn Infant

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. (For more information, see Item 2 on a following page).

Explanation of Form Items Table (continued)

Item	Description
2	<p>Patient’s Name. Enter the recipient’s last name, first name, and middle initial (if known). Avoid nicknames or aliases.</p>

Explanation of Form Items Table (continued)

Item	Description
2	<p>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 yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn also must be designated by a number or letter (example: Jones Baby Girl Twin A). Providers may also wish to use the <i>Patient's Account No.</i> field (Box 26) to enter Twin A (or B). This is not a required field, and only for provider convenience. This field is repeated in all payment information (such as the <i>Remittance Advice Details</i> [RAD]), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.</p> <p>Enter the infant's sex and date of birth in Box 3 and check the <i>Child</i> box in Box 6 (<i>Patient's Relationship to Insured</i>). Enter the mother's name in Box 4 (<i>Insured's Name</i>).</p> <p>Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number. To facilitate reimbursement for infants (including twins) using the mother's ID number, enter Newborn Infant Using Mothers ID in the <i>Additional Claim Information</i> (Box 19) or Newborn Infant Using Mother's ID (Twin A) or (Twin B).</p>
3	<p>Patient's Birth Date/Sex. Enter the recipient's date of birth in six-digit MMDDYY (Month, Day, Year) format (for example, September 1, 1963 = 090163). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns, see Item 2).</p> <p>If the recipient is 100 years or older, enter the recipient's age and the full <u>four</u>-digit year of birth in the <i>Additional Claim Information</i> field (Box 19).</p> <p>«Enter an "X" in the "M" or "F" box. (For newborns, see Item 2.)»</p>
4	<p>Insured's Name. Not required by Medi-Cal, except when billing for an infant using the mother's ID. Enter the mother's name in this field when billing for the infant.</p>

Explanation of Form Items Table (continued)

Item	Description
5	Patient's Address/Telephone. Enter recipient's complete address and telephone number.
6	Patient Relationship to Insured. Not required by Medi-Cal. This field may be used when billing for an infant using the mother's ID by checking the <i>Child</i> box.
7	Insured's Address. Not required by Medi-Cal.
8	Reserved for NUCC Use. Not required by Medi-Cal.
9	Other Insured's Name Not required by Medi-Cal.
9a	Other Insured's Policy or Group Number. Not required by Medi-Cal.
9b	Reserved for NUCC Use. Not required by Medi-Cal.
9c	Reserved for NUCC Use. Not required by Medi-Cal.
9d	Insurance Plan Name or Program Name. Not required by Medi-Cal.
10	Is Patient Condition Related To:
10a	Employment. Complete this field if services were related to an accident or injury. Enter an "X" in the <i>Yes</i> box if accident/injury is employment related. Enter an "X" in the <i>No</i> box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the <i>Date of Current Illness, Injury or Pregnancy</i> field (Box 14).
10b	Auto Accident/Place. Not required by Medi-Cal.
10c	Other Accident. Not required by Medi-Cal.
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 full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about SOC, refer to the <i>Share of Cost (SOC)</i> section in the Part 1 manual. Also refer to the <i>Share of Cost (SOC): CMS-1500</i> section in the appropriate Part 2 manual.»

«Explanation of Form Items Table (continued)»

Item	Description
11	Insured's Policy Group or FECA Number. Not required by Medi-Cal.
11a	Insured's Date of Birth/Sex. Not required by Medi-Cal.
11b	Other Claim ID (Designated by NUCC). Not required by Medi-Cal.
11c	Insurance Plan Name or Program Name. For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.
11d	<p>Is There Another Health Benefit Plan. Enter an "X" in the Yes box if recipient has Other Health Coverage (OHC). OHC includes insurance carriers, Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) who provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered Other Health Coverage.</p> <p>Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Part 1 manual.</p> <p>If the Other Health Coverage has paid, enter the amount in the upper right side of this field as shown in <i>Figure 2</i> on a following page in this section. Do not enter a decimal point or dollar sign (\$).</p>
12	Patient's or Authorized Person' Signature. Not required by Medi-Cal.
13	Insured's or Authorized Person's Signature. Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.
14	Date of Current Illness, Injury or Pregnancy (LMP). Enter the date of 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.
15	Other Date. Not required by Medi-Cal.
16	Dates Patient Unable to Work in Current Occupation Not required by Medi-Cal.

«Explanation of Form Items Table (continued)»

Item	Description
17	<p>Name of Referring Provider or Other Source. Indent to the right of the dotted line and 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 non-physician medical practitioner must be entered.</p> <p>Note: Providers billing lab service for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.</p>
17a	<p>Unlabeled. Not required by Medi-Cal.</p>
17b	<p>NPI. Enter the National Provider Identifier (NPI).</p> <p><u>Boxes 17 and 17b must be completed by the following providers:</u></p> <ul style="list-style-type: none"> • Clinical laboratory (services billed by laboratory) • Durable Medical Equipment (DME) and medical supply • Hearing aid dispenser • Orthotist • Prosthetist • Nurse anesthetist • Occupational therapist • Physical therapist • Podiatrist (when services are rendered in a Skilled Nursing Facility [NF Level A or B]) • Portable imaging services • Radiologist • Speech pathologist • Audiologist • Pharmacies

«Explanation of Form Items Table (continued)»

Item	Description
<p>17b (continued)</p>	<p>Boxes 17 and 17b (continued)</p> <p><u>In-State Referring Provider.</u> A Universal Provider Information Number (UPIN) is not allowed.</p> <p><u>Out-of-State Referring Provider:</u> Claims must include a referring provider number using the referring provider’s individual (not group) number. A license number or UPIN is not allowed.</p> <p><u>Dental Referring Providers: In-State.</u> Claims must include a referring provider number. Add the prefix “DDS” to the referring provider license number on the claim. A provider number or UPIN is not allowed.</p> <p><u>Dental Referring Providers: Out-of-State.</u> Claims must include a referring provider number. Add the prefix “DEN” to the referring provider license number on the claim. UPINs are not allowed.</p> <p>A non-physician medical practitioner authorized to refer with the physician’s provider number should include the number of the supervising physician on the referral. The billing provider also should enter the number of the supervising physician. Claims with a non-physician medical practitioner number will not be reimbursed.</p> <p>When a billing provider receives a denial due to an invalid referring provider number, the referring provider should be contacted to verify the status of the provider number.</p> <p>A physician’s assistant (and other non-physician practitioners authorized to refer with the physician’s number) should include the provider number of the supervising physician on the referral. The billing provider should enter the provider number of the supervising physician. Claims with a Non-physician Medical Practitioner (NMP) license number will not be reimbursed.</p> <p>Note: Referring providers who would like to participate in the Medi-Cal program may contact the Telephone Service Center (TSC) at 1-800-541-5555.</p>
<p>18</p>	<p>Hospitalizations 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.</p>

Attachments

Explanation of Form Items Table (continued)

Item	Description
19	<p>Additional Claim Information (Designated by NUCC). Use this area for procedures that require additional information or justification. For specific “By Report” attachment requirements, refer to the <i>CMS-1500 Special Billing Instructions</i> section of this manual.</p> <p>Claims for “By Report” codes, complicated procedures (modifier 22), unlisted services and anesthesia time require attachments. This information may also be entered in the <i>Additional Claim Information</i> field (Box 19) if space permits.</p> <p>«Reports are not required for routine procedures. Non-reimbursable CPT® codes are listed in the <i>TAR and Non-Benefit List: Codes 10000 thru 99999</i> and <i>0001M thru 0999U</i> sections of the appropriate Part 2 manual.» Refer to “Attachments” in the <i>CMS-1500 Special Billing Instructions</i> section in this manual, the CPT book or in the appropriate policy sections for details.</p> <p>Note: Please do not staple attachments.</p>
20	<p>Outside Lab? If this claim includes charges for laboratory work performed by a licensed laboratory, enter an “X.” “Outside” laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank if not applicable.</p> <p>Outside Lab Monetary Charges. Not required by Medi-Cal.</p>
21	<p>Diagnosis or Nature of Illness or Injury. Relate A to L to service line below (24E).</p> <p>ICD Ind. Enter the appropriate ICD indicator, either a “9” or “0”, depending on the date of service for the claim. Claims submitted without a diagnosis code do not require an ICD indicator.</p>

«Explanation of Form Items Table (continued)»

Item	Description
21A	<p>Diagnosis or Nature of Illness or Injury Enter all letters and/or numbers of the ICD-10-CM code for the <u>primary</u> diagnosis, including fourth through seventh characters, if present. (Do <u>not</u> enter decimal point).</p> <p>The following services are exempt from diagnosis descriptions and codes when they are the only services billed on the claim:</p> <ol style="list-style-type: none"> 1. Anesthesia services 2. Assistant surgeon services 3. Medical supplies and materials (includes DME [except incontinence supplies]), hearing aids, orthotic and prosthetic appliances 4. Medical transportation 5. Pathology services (referenced in the CPT book) 6. Radiology services (except: CAT scan, nuclear medicine, ultrasound, radiation therapy, and portable imaging services, which <u>require</u> diagnosis codes).
21B	<p>Diagnosis or Nature of Illness or Injury. If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code, including fourth through seventh characters, if present. (Do <u>not</u> enter decimal point.)</p> <p>Note: Medi-Cal only accepts two diagnosis codes. Codes entered in Boxes 21.C thru L will not be used for claims processing.</p> <p>Note to Incontinence Supply Providers: Only the following ICD-10-CM codes will be accepted as the secondary diagnosis.</p> <ul style="list-style-type: none"> • F98.0 • F98.1 • N39.3 • N39.41 thru N39.46 • N39.490 thru N39.492 • N39.498

«Explanation of Form Items Table (continued)»

Item	Description
21 B (continued)	<ul style="list-style-type: none"> • R15.2 • R15.9 • R30.1 • R32 • R39.2 • R39.81 thru R39.9
21 C thru L	Diagnosis or Nature of Illness or Injury. Not required by Medi-Cal.
22	Resubmission Code/Original Reference Number. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are «in the table below».

«Table of Medicare Status Codes and Explanations (Item 22)»

Code	Explanation
0	Under 65, does not have Medicare coverage
1†	Benefits exhausted
2†	Utilization committee denial or physician non-certification
3†	No prior hospital stay
4†	Facility denial
5†	Non-eligible provider
6†	Non-eligible recipient
7†	Medicare benefits denied or cut short by Medicare intermediary
8†	Non-covered services
9†	PSRO denial
L†	Medi/Medi Charpentier: Benefit Limitations
R†	Medi/Medi Charpentier: Rates
T†	Medi/Medi Charpentier: Both Rates and Benefit Limitations

Explanation of Form Items Table (continued)

Item	Description
23	<p>Prior Authorization Number. For physician and podiatry services requiring a <i>Treatment Authorization Request (TAR)</i>, enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim. Refer to the <i>CMS-1500 Special Billing Instructions</i> section in this manual for more information.</p> <p>«Note: TAR and non-TAR procedures should not be combined on the same claim.»</p>
24.1	<p>Claim Line. Information for completing a claim line follows in Items 24A thru 24J. Refer to the <i>CMS-1500 Special Billing Instructions</i> section in this manual for more information.</p> <p>Note: Do not enter data in the shaded area except as noted for Boxes 24A, C and D</p>
24A	<p>Date (S) of Service. In the unshaded area, enter the date the service was rendered in the “From” and “To” boxes in the six-digit, MMDDYY (Month, Day, Year) format; for example, April 2, 2013 written as 040213. Refer to the <i>CMS-1500 Special Billing Instructions</i> section in this manual for more information.</p> <p>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). Refer to the <i>Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions</i> section in this manual for more information.</p> <p>Universal Product Number (UPN) for contracted disposable incontinence and medical supplies: In the shaded area, enter the appropriate UPN qualifier followed by the UPN.</p> <p>The following is a list of UPN qualifiers. Claims for contracted disposable incontinence and medical supplies require the UPN qualifiers as published in the appropriate Part 2 manual.</p>

Table of UPN Qualifiers and Descriptions (Item 24A)

Qualifier	Description	Number of Characters
HI	Health Care Industry Bar Code (HIBC)	6-18
EO	GTIN EAN/UCC	8
UP	Consumer Package Code U.P.C	12
EN	European Article Number (EAN)	13
UK	U.P.C./EAN Shipping Container Code	14
ON	Customer Order Number	1-19

Explanation of Form Items Table (continued)

Item	Description
24B	Place of Service. Enter one code from the list below indicating where the service was rendered:

Table of Place of Service Codes (Item 24B)

Code	Place of Service
01	Pharmacy
02	Telehealth Provided Other than in Patient's Home
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
<<09	Correctional Facility>>
10	Telehealth Provided in Patient's Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic
25	Birthing Center

Table of Place of Service Codes (Item 24B) (continued)

Code	Place of Service
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF)
32	Nursing Facility (NF)
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

Note: If subacute care, specify the appropriate Place of Service and use modifier U2.

Explanation of Form Items Table (continued)

Item	Description
24C	<p>EMG. Emergency or delay reason codes.</p> <p>Delay Reason Code: If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. 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. (Refer to the <i>CMS-1500 Submission and Timeliness Instructions</i> section in this manual).</p>

Explanation of Form Items Table (continued)

Item	Description
24C (continued)	<p>«Emergency Code: Enter an “X” or “Y” 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 OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist, dentist or pharmacist’s statement, describing the nature of the emergency, including relevant clinical information about the patient’s condition. A mere statement that an emergency existed is not sufficient.</p>
24D	<p>Procedures, Services or Supplies/Modifier. Enter the applicable procedure code (HCPCS or CPT) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Medi-Cal accepts up to four modifiers for a procedure on a single claim line. Enter modifiers in the boxes provided.</p> <p>Note: Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier UD in the modifier area of Box 24D. Section 340B drugs may be billed on the same claim as non-340B drugs.</p>

Unit of Measure Qualifier/ Numeric Quantity

Claims for physician-administered drugs and contracted incontinence or disposable medical supplies may include a two-character unit of measure qualifier (F2 [International Unit], GR [gram], ML [milliliter] or UN [unit]) followed by a numeric quantity.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

On the *CMS-1500* claim, the unit of measure qualifier and numeric quantity combined are 12 characters long. The qualifier is the first two characters and the quantity is 10 digits as follows: Digits 1-7 are the whole number portion of the quantity. Digits 8-10 are the decimal portion and must be entered whether or not there is a decimal portion to be reported. (Decimal example: For a quantity of 124.54 milliliters enter ML0000124540.)

Products billed as “each,” “inches” or “yards” with a unit of measure that is a whole number (no decimal portion) are billed as follows:

“The unit of measure qualifier/numeric quantity number is entered on the claim in 12-character format with the first two characters being “UN” and the last three “000.” For example, one “ea” item would be entered on the claim as UN0000001000, 16 “yd” (per yard) items as UN0000016000, and 240 “inch” (per inch) items as UN00000240000.”

See the following “Physician-Administered Drugs” and “Incontinence and Disposable Medical Supplies” entries for more information.

Physician-Administered Drugs

If the item being billed is a physician-administered drug, enter in the shaded area above the procedure code the two-character unit of measure qualifier directly followed by the numeric quantity administered to the patient. Refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual for more information.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Incontinence and Disposable Medical Supplies

If the item being billed is an incontinence or disposable medical supply, enter the product’s HCPCS Level II code. (For codes see the *Incontinence Products* or *Medical Supply Products* sections of the *Part 2 Durable Medical Equipment [DME] and Medical Supplies or Pharmacy* manual). Enter the two-character unit of measure qualifier directly followed by the numeric quantity in the shaded area above the procedure code.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Medicare/Medi-Cal Recipients

Medicare non-covered services codes are listed in the Medicare non-covered services codes sections in this manual. Only those services listed in the Medicare non-covered sections may be billed directly to Medi-Cal. All others must be billed to Medicare first.

For a listing of approved CPT and Medi-Cal-only modifier codes, refer to *the Modifiers: Approved List* section in the appropriate Part 2 manual.

To determine if a medical supply must be billed to Medicare prior to billing Medi-Cal, refer to the *Medical Supplies: Medicare Covered Services* section in the appropriate Part 2 manual. Those medical supplies listed in *Medical Supplies: Medicare Covered Services* section must be billed to Medicare prior to billing Medi-Cal.

Explanation of Form Items Table (continued)

Item	Description
24E	Diagnosis Pointer. As required by Medi-Cal.

Laboratory Charges**Explanation of Form Items Table (continued)**

Item	Description
24F	<p>Charges. In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000, not 100). If an item is a taxable medical supply, include the applicable state and county sales tax.</p> <p>When billing “outside” laboratory work, enter the actual amount charged by the laboratory in Box 24F. Handling charges must be billed as a separate line item.</p>

Billing for Time**Explanation of Form Items Table (continued)**

Item	Description
24G	<p>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.</p> <p>The field permits entries of up to 999. For entries greater than 999, carry the remaining value to the next claim line. For example, if the entry value is 1236, the first claim line should read, “999”; the second claim line should read, “237.” Both figures total the original value of “1236.”</p> <p>Do not enter a decimal point. Therefore, a quantity of “1” entered anywhere in the field, or with leading zeroes, would be seen by the Medi-Cal system as “001” and a “10” entered anywhere in the field would be seen as “010.”</p> <p>Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “4”).</p>
24H	<p>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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening related.» Leave blank if not applicable. Refer to the codes in the table below.</p>

Table of EPSDT Family Plan Codes and Descriptions (Item 24 H)

Code	Description
1	Family Planning/Sterilization (Sterilization Consent Form must be attached to the claim if code 1 is entered)
2	Family Planning/Other
3	«EPSDT Screening Related»

Refer to the *Family Planning* section of the appropriate Part 2 manual for further details.

Explanation of Form Items Table (continued)

Item	Description
24I	ID Qualifier for Rendering Provider. Not required by Medi-Cal
24J	Rendering Provider ID Number. 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.

Deleting Information Items 24A thru 24J:

If an error has been made to specific billing information entered on Items 24A thru 24J, draw a line through the entire detail line using a blue or black ballpoint pen. Enter the correct billing information on another line.

Note: Do not “black-out” entire claim line. Deleted information may be used to determine previous payment.

	24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	(Explain Unusual Circumstances)			CPT/HCPCS	MODIFIER							
1	11	01	05	11		97810	A3		50.00	1		NPI	0123456789	
2	11	01	05	11		97810	A1		75.00	1		NPI	0123456789	
3												NPI		
4												NPI		
5												NPI		
6												NPI		

Figure 2: Sample of Deleted Information.

«Explanation of Form Items Table (continued)»

Item	Description
24.2 thru 24.6	Additional Claim Lines. Follow instructions for each claim line
25	Federal Tax I.D. Number. Not required by Medi-Cal.
26	Patient's Account Number. This is an optional field that will help providers to easily identify a recipient on a <i>Remittance Advice Details</i> (RAD). Enter the patient's control number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RAD. Refer to the <i>Remittance Advice Details</i> (RAD) examples sections in this manual.
27	Accept Assignment? Not required by Medi-Cal.
28	Total Charge. In full dollar amount, enter the total for all services. Do not enter a decimal point or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100).
29	Amount Paid. Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D). Do not enter a decimal point or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). <u>Do not enter Medicare payments in this box.</u> The Medicare payment amount will be calculated from the Medicare <i>Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)/Remittance Advice (RA)</i> when submitted with the claim.
30	Rsvd for NUCC USE. Effective September 22, 2014, providers no longer complete this field.
31	Signature of Physician or Supplier Including Degrees or Credentials The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only. An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.
32	Service Facility Location Information. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office. Note: Not required for clinical laboratories when billing for their own services.

«Explanation of Form Items Table (continued)»

Item	Description
32a	Enter the NPI of the facility where the services were rendered.
32b	Enter the Medi-Cal provider number for an atypical service facility.
33	<p>Billing Provider Info and Phone Number. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number.</p> <p>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.</p>
33a	Enter the billing provider's NPI.
33b	<p>Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.</p> <p>Note: Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.</p>

Check Digits

For atypical providers, DHCS assigns a check digit to each provider to verify accurate input of the Medi-Cal provider number. The check digit is not a required item. However, including the check digit ensures that reimbursement for the claim is made to the correct provider. Providers should enter their check digit to the right of the Medi-Cal provider number in Box 32B. Providers who do not know their check digit should contact the Telephone Service Center (TSC) at 1-800-541-5555.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
†	Documentation required. Refer to the <i>Medicare/Medi-Cal Crossover Claims: CMS-1500</i> section in this manual for additional information