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Claim Form Instructions CMS 1500

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

SAMPLE

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? PLACE (State) YES NO

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 ______

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

29. AMOUNT PAID $

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

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

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided. Not required (NR) fields are optional.

NOTE: Claims with missing or invalid required (R) field information will be rejected or denied.

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
1	INSURANCE PROGRAM IDENTIFICATION	• Check only the type of health coverage applicable to the claim. • This field indicates the payor to whom the claim is being paid. Enter “X” in the box noted “Other.”	R
1A	INSURED’S ID NUMBER	Enter the 9-digit identification number on the member’s Health Plan ID Card.	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	• Enter the patient’s name as it appears on the member’s Health Plan ID card. • Do not use nicknames.	R
3	PATIENT’S BIRTH DATE/SEX	• Enter 6-digit or 8-digit DOB: MM DD YY -OR- MM DD YYYY • Enter an X to indicate the sex (gender) of the insured. **NOTE:** Only one box can be marked. If gender is unknown, leave blank.	R
4	INSURED’S NAME	Enter the patient’s name as it appears on the member’s Health Plan ID Card.	C
5	PATIENT’S ADDRESS • Address Number & Street • City, State, & Zip Code • Phone Number (including area code)	Enter the patient’s complete address and telephone number, including area code on the appropriate line. **1st line:** Enter the street address. Do not use commas, periods, or other punctuation in the address. EXAMPLE: ☑ 123 N Main Street 101 ☒ 123 N. Main Street, #101 **2nd line:** Enter the City and State, in the designated block. **3rd line:** Enter the Zip Code and Phone Number. Include a hyphen when entering a 9-digit zip code (zip+4) - EXAMPLE: ☑ 54321-1234 ☒ 543211234 Do not use a hyphen or space when entering a phone number. - EXAMPLE: ☑ (515)5551212 ☒ (515) 5551212 ☒ 515-555-1212 ☒ 515.555.1212 **NOTE:** Patient phone number does not exist in the electronic 837P.	C
6	PATIENT’S RELATION TO INSURED	Always mark to indicate self.	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
7	INSURED'S ADDRESS • Address Number & Street • City, State, & Zip Code • Phone Number (including area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. **1st line:** Enter the street address. Do not use commas, periods, or other punctuation in the address. EXAMPLE: ☑ 123 N Main Street 101 ☒ 123 N. Main Street, #101 **2nd line:** Enter the City and State, in the designated block. **3rd line:** Enter the Zip Code and Phone Number. Include a hyphen when entering a 9-digit zip code (zip+4) EXAMPLE: ☑ 54321-1234 ☒ 543211234 Do not use a hyphen or space when entering a phone number. - EXAMPLE: ☑ (515)5551212 ☒ (515) 5551212 ☒ 515-555-1212 ☒ 515.555.1212 **NOTE:** Patient phone number does not exist in the electronic 837P.	C
8	RESERVED FOR NUCC USE		NR
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. **REQUIRED** when patient is covered by another insurance plan. • Enter the complete name of the insured.	C
9A	*OTHER INSURED'S POLICY OR GROUP NUMBER	**REQUIRED** if field 9 is completed. • Enter the policy or group number of the other insurance plan.	C
9B	RESERVED FOR NUCC USE		NR
9C	RESERVED FOR NUCC USE		NR
9D	INSURANCE PLAN NAME OR PROGRAM NAME	**REQUIRED** if field 9 is completed. • Enter the policy or group number of the other insurance plan.	C
10A, B, C	IS PATIENT'S CONDITION RELATED TO: (Employment, Auto Accident, Other Accident?)	• Enter 6-digit or 8-digit DOB: MM DD YY -OR- MM DD YYYY • Check Yes or No for each field (A, B, and C). • Do not check Yes and No to same line item. • When A, B, or C are marked Yes, primary insurance information must be shown in field 11.	R
10D	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
11	INSURED POLICY OR FECA NUMBER	**REQUIRED** when 10A, 10B, or 10C are marked Yes. • Enter the policy, group, or FECA number of the other insurance when field 10A, B, and/or C is marked Yes.	C
11A	INSURED'S DATE OF BIRTH / SEX	• Enter the Insured's 8-digit DOB: MM DD YYYY • Enter an X to indicate the sex (gender) of the insured. **NOTE:** Only one box can be marked. If gender is unknown, leave blank.	C
11B	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier have been designated for use: • Y4 Property Casualty Claim Number **REQUIRED: FOR WORKERS' COMPENSATION OR PROPERTY CASUALTY** Enter the claim number assigned by payor, if known.	C
11C	INSURANCE PLAN NAME OR PROGRAM NAME	Enter name of the insurance health plan or program.	C
11D	IS THERE ANOTHER HEALTH BENEFIT PLAN	Check Yes or No. **NOTE:** If Yes, complete items 9, 9A, 9D, and 11C.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. **REQUIRED:** The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	NR
14	DATE OF CURRENT: • ILLNESS (First Symptom) • INJURY (Accident) or • PREGNANCY (LMP)	• Enter the 6-digit or 8-digit date of the first date of the present illness, injury, or pregnancy. MM DD YY -OR- MM DD YYYY • For pregnancy, use the date of the last menstrual period (LMP) as the first date. • Enter the applicable qualifier to identify which date is being reported: ○ 431 Onset of Current Symptoms or Illness ○ 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another 6-digit or 8-digit date related to the patient's condition or treatment. MM DD YY -to- MM DD YY -OR- MM DD YYYY -to- MM DD YYYY	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Enter 6-digit or 8-digit dates patient is unable to work related to their condition or treatment. MM DD YY -to- MM DD YY -OR- MM DD YYYY -to- MM DD YYYY	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional & credentials. • First name, middle initial, last name, and credentials EXAMPLE: John A Smith MD	C
17A	ID NUMBER OF REFERRING PHYSICIAN	**REQUIRED:** Use ZZ qualifier for Taxonomy code if field 17 is completed.	C
17B	NPI NUMBER OF REFERRING PHYSICIAN	**REQUIRED:** NPI of referring physician if field 17 is completed. • Servicing NPI may be used if unable to obtain referring NPI.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter 6-digit or 8-digit dates patient is unable to work related to their condition or treatment. MM DD YY -to- MM DD YY -OR- MM DD YYYY -to- MM DD YYYY	C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items A-L to item 24E, by line.) **NOTE:** New form allows up to 12 diagnoses and ICD indicator.	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. • Relate lines A - L to the lines of service in 24E by the letter of the line. • Use the highest level of specificity. • Do not provide narrative description in this field. • Services requiring a diagnosis for payment (example: Emergent Diagnosis, DRG and IHAWP sleep apnea claims), the diagnosis must be in the primary diagnosis position. **NOTE: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.**	R

22	RESUBMISSIO N CODE / ORIGINAL REF.NO.	For resubmissions or adjustments, enter the original claim number of the original claim.
		• New form – for resubmissions only
		  ○ 7 – Replacement of Prior Claim (Corrected Claim)
		  ○ 8 – Void/Cancel Prior Claim.
			C

23	PRIOR AUTHORIZATI ON NUMBER or CLIA NUMBER	Enter the authorization or referral number. • Refer to the Provider Manual for information on services requiring referral and/or prior authorization. • CLIA number for CLIA waived or CLIA certified laboratory services.	If auth: C If CLIA: R If both: always submit the CLIA number

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)

24A-J General Information	**Box 24 contains six claim lines. Each claim line is split horizontally into shaded and unshaded areas.**
	• Shaded area of claim lines
	  ○ Four individual fields labeled 24A - 24J.
	  ○ Fields 24A through 24G are continuous fields for the entry of supplemental information.
	• Unshaded area of a claim line
	  ○ Ten individual fields labeled 24A - 24J.
	Instructions below are provided for shaded and unshaded fields.
	• Shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number.
	• Shaded boxes 24A - 24G are for line-item supplemental information and provide a continuous line that accepts up to 61 characters.
	  ○ Refer to the instructions listed below for information on how to complete.
	• If you are a FQHC/RHC/Indian Health Center, Chapter 24 provider or have a provider with an atypical NPI, leave box 24J blank or use your billing NPI in this box.
	• The unshaded area of a claim line is for the entry of claim line-item detail.		

24A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract Rate	C
24A Unshaded	DATE(S) OF SERVICE	Enter the 6-digit or 8-digit date the service listed in field 24D was performed. MM DD YY -OR- MM DD YYYY • If there is only one date, enter that date in the “From” field. • The “To” field may be left blank or populated with the “From” date. • If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. • A list of current POS Codes may be found on the CMS website.	R
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	NR

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. • Only one CPT or HCPC and up to four modifiers may be entered per claim line. • Codes entered must be valid for date of service. • The first modifier entered is the only modifier used for pricing the claim. ○ Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. • Missing or invalid codes will be denied for payment.	R
24E Unshaded	DIAGNOSIS CODE	Enter the diagnosis code reference letter (pointer) as shown in field # 21 to relate the date of service and the procedures performed to the primary diagnosis. • When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. ○ The reference letter(s) should be A – L or multiple letters as applicable. • ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Field 21 only. Do not enter them in 24E. • Do not use commas between the diagnosis pointer numbers. • Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24F Unshaded	CHARGES	Enter the charge amount for the claim line-item service billed. • Dollar amounts to the left of the vertical line should be right justified. • Up to eight characters are allowed (i.e. 199,999.99). • Do not use commas. • Do not enter a dollar sign ($). • If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). • Enter a numeric value of one if only one service provided	R
24H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed because of an EPSDT referral.	C
24H Unshaded	EPSFT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
24I Shaded	ID QUALIFIER	• Use ZZ qualifier for Taxonomy. • Use 1D qualifier for ID if an Atypical Provider	R
24J Shaded	NON-NPI PROVIDER ID#	**Typical Providers** • Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. **Atypical Providers** • Enter the Provider ID number.	R
24J Unshaded	NPI PROVIDER ID	**Typical Providers ONLY:** Enter the 10-character NPI ID of the provider who rendered services. • If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. • Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX ID NUMBER/ SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an **X** in the YES box: Submission of a claim for reimbursement of services provided to a Health Plan Member using state funds indicates the provider accepts assignment. • Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. • Dollar amounts to the left of the vertical line should be right justified. • Up to eight characters are allowed (i.e. 199999.99). • Do not use commas. • Do not enter a dollar sign ($). • If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
29	AMOUNT PAID	**REQUIRED** when another carrier is the primary payor. Enter the payment received from the primary payor prior to invoicing the Health Plan. **Medicaid programs are always the payors of last resort.** • Dollar amounts to the left of the vertical line should be right justified. • Up to eight characters are allowed (i.e. 199999.99). • Do not use commas. • Do not enter a dollar sign ($). • If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	**REQUIRED** when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payor). • Dollar amounts to the left of the vertical line should be right justified. • Up to eight characters are allowed (i.e. 199999.99). • Do not use commas. • Do not enter a dollar sign ($). • If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials)	• You may stamp, print, or computer-generate the signature if there is a signature waiver on file; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. • **If signature is missing or invalid, the claim will be returned unprocessed.** **NOTE:** Signature does not exist in the electronic 837P.	R

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED when the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. • P.O. Box numbers are not acceptable here. • Do not use commas, periods, or other punctuation in the address **1st line:** Enter the business/facility/practice name. **2nd line:** Enter the street address. EXAMPLE: ☑ 123 N Main Street 101 ☒ 123 N. Main Street, #101 **3rd line:** Enter the City and State, in the designated block. **4th line:** Enter the Zip Code. Include a hyphen when entering a 9-digit zip code (zip+4) EXAMPLE: ☑ 54321-1234 ☒ 543211234	C
32A	NPI – SERVICES RENDERED	**Typical Providers ONLY** **REQUIRED** if the location where services were rendered is different from the billing address listed in field 33. • Enter the 10-character NPI ID of the facility where services were rendered.	C

32B	OTHER PROVIDER ID	**REQUIRED** if the location where services were rendered is different from the billing address listed in field 33.
		• **Typical Providers**
		  ○ Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces).
		• **Atypical Providers**
		  ○ Enter the 2-character qualifier 1D (no spaces).
			C

Field Number	Field Description	Instructions or Comments	Required (R) Not Required (NR) Conditional (C)
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (including the 9-digit zip code), and phone number. **1st line:** Enter the business/facility/practice name. **2nd line:** Enter the street address. Do not use commas, periods, or other punctuation in the address. EXAMPLE: ☑ 123 N Main Street 101 ☒ 123 N. Main Street, #101 **3rd line:** Enter the City and State, in the designated block. **4th line:** Enter the full 9-digit Zip Code (zip+4) and Phone Number. Include the hyphen when entering zip code. **NOTE:** The full 9-digit zip code is required for paper and EDI claim submission. EXAMPLE: ☑ 54321-1234 ☒ 543211234 Do not use a hyphen or space when entering a phone number. EXAMPLE: ☑ (515)5551212 ☒ (515) 5551212 ☒ 515-555-1212 ☒ 515.555.1212	R
33A	GROUP BILLING NPI	<u>**Typical Providers ONLY**</u> **REQUIRED** if the location where services were rendered is different from the billing address listed in field 33. • Enter the 10-character NPI ID.	R
33B	GROUP BILLING OTHERS ID	Enter the Billing Group Taxonomy code as designated below. • **Typical Providers** ○ Enter the Provider Taxonomy Code. ○ Use ZZ qualifier. • **Atypical Providers** ○ Enter the Provider ID number	R