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.

Module Objectives

- Identify provider manual sections with *CMS-1500* claim form completion instructions
- Introduce general billing guidelines for the completion and submission of the *CMS-1500* claim form
- Review common claim form completion errors
- Complete sample *CMS-1500* claim form scenarios

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (*www.medi-cal.ca.gov/mcss*).

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)

Other References

Medi-Cal Learning Portal e-learning tutorial for *CMS-1500* claim form completion (*http://learn.medi-cal.ca.gov*)

Acronyms

A list of current acronyms is located in the *Appendix* section of this 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 Department of Health Care Services (DHCS) 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 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 unacceptable.
- 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.

Form Completion Instructions

- Handwritten claims should be printed neatly using <u>black</u> ballpoint pen ONLY.
- 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 “BK” 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 (ACF), 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 transaction.

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

Xerox State Healthcare, LLC
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.
- Providers should not fax attachments the same day as submitting the claim electronically.

NOTE
A 24 hour hold is required before faxing documents when billing electronically.

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 or a photocopy of an ACF is 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.
- If documents are faxed the same day a claim is billed electronically, the claim can be denied.

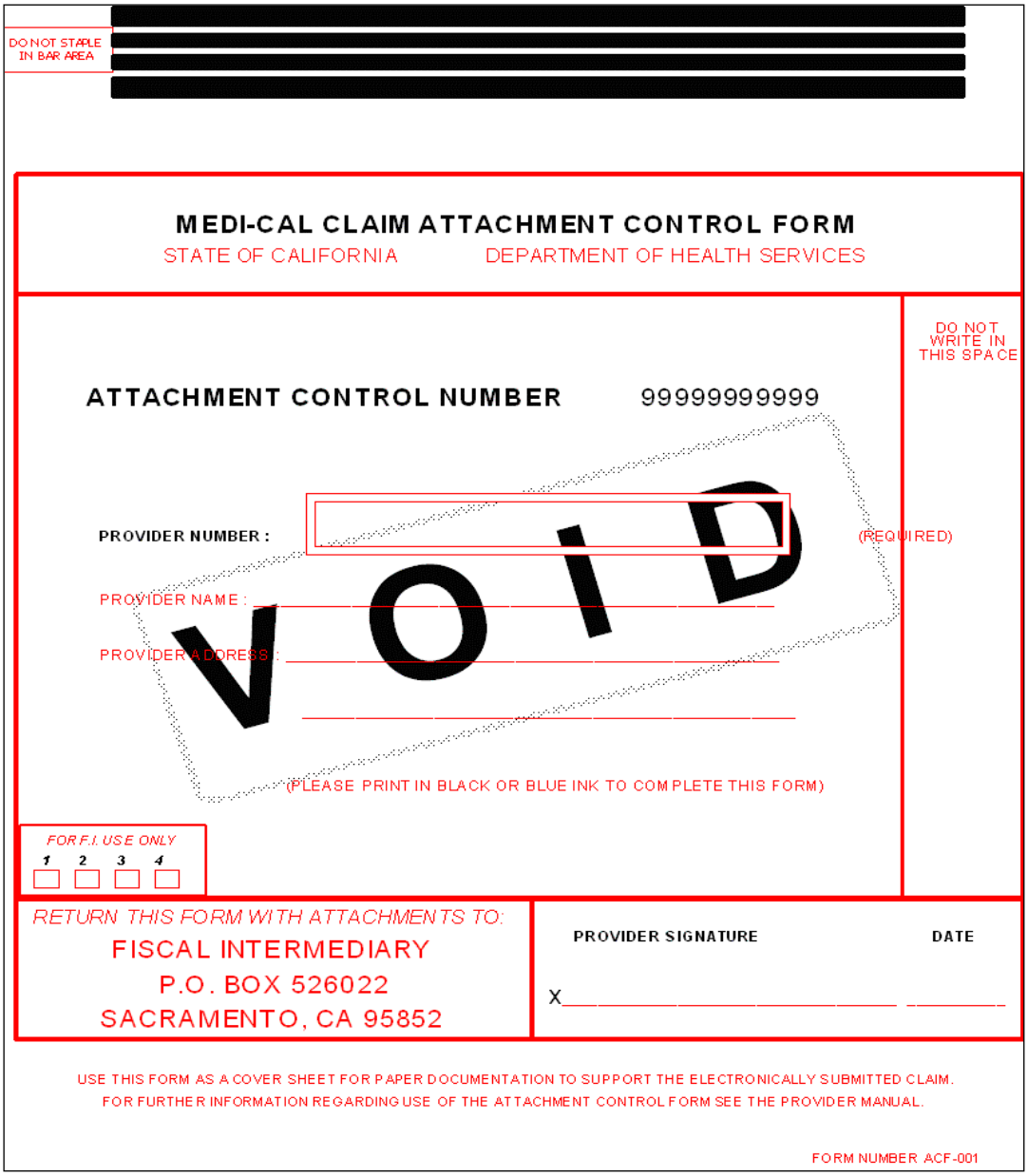
ACF Order/Reorder Instructions

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) in 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.


DO NOT STAPLE IN BAR AREA

MEDI-CAL CLAIM ATTACHMENT CONTROL FORM
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

DO NOT WRITE IN THIS SPACE

ATTACHMENT CONTROL NUMBER 99999999999

PROVIDER NUMBER : (REQUIRED)

PROVIDER NAME :

PROVIDER ADDRESS :

VOID

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

FOR F.I. USE ONLY
1 2 3 4

RETURN THIS FORM WITH ATTACHMENTS TO:
FISCAL INTERMEDIARY
P.O. BOX 526022
SACRAMENTO, CA 95852

PROVIDER SIGNATURE DATE

X

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM.
FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001

ACF Example

Xerox State Healthcare, LLC
820 Stillwater Road
West Sacramento, CA 95605

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 Services 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 - 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 at 1-800-541-5555.

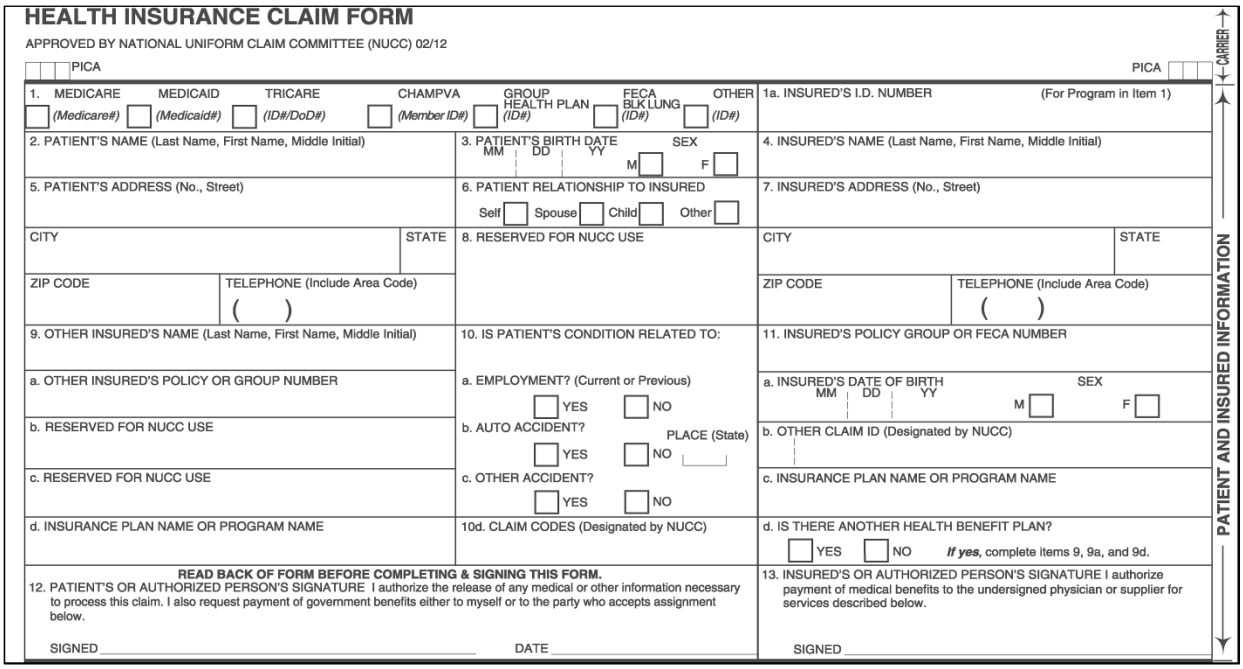
Sincerely,

ACF Rejection Letter

CMS-1500 Claim Form Completion

CMS-1500 Claim Form (Fields 1 – 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 | PICA

CARRIER

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 _____

PATIENT AND INSURED INFORMATION

Sample Partial *CMS-1500* Claim Form

NOTES

_____

_____

_____

_____

_____

Field Descriptions: 1 – 5

Box #	Field Name	Instructions
1	MEDICAID/ MEDICARE/ OTHER ID	For Medi-Cal, enter an “X” in the *Medicaid* box. **Billing Tip:** When billing Medicare crossover claims, check both the _____ and _____ 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, enter mother’s ID number in this field. **Billing Tip:** Use the _____ _____ 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).* **Billing Tip – 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 _____ _____ or _____ _____.
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 (as shown on the BIC). **Billing Tip – 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. **Billing Tip – Newborn Infant:** Enter the _____ _____ in the *Insured’s Name* field (Box 4).
5	PATIENT’S ADDRESS AND TELEPHONE	Enter the recipient’s complete address and telephone number.

Field Descriptions: 6 – 11D

Box #	Field Name	Instructions
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.
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).
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).
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. **Billing Tip:** Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's _____ _____ _____ prior to billing Medi-Cal. Eligibility under Medicare or Medi-Cal Managed Care Plan (MCP) is not considered OHC.

Answer Key: 1) Medicaid, Medicare; 1A) POS network; 2) BABY BOY, BABY GIRL; 4) mother's name; 11D) other health coverage

CMS-1500 Claim Form (Fields 14 – 33)

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** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample: Partial *CMS-1500* Claim Form

Field Descriptions: 14 – 20

Box #	Field Name	Instructions
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).
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. However, the NPI of the supervising physician needs to be entered in box 17B, below.
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 • Pharmacy • Physical therapist • Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B) • Portable X-ray • Prosthetist • Radiologist • Speech pathologist
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.
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Use this area for procedures that require additional information, justification or an *Emergency Certification Statement*. **Billing Tip:** "By Report" codes, complicated procedures, unlisted services and anesthesia time require _____. 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.

Answer Key: 19) attachments;

Field Descriptions: 21 – 24B

Box #	Field Name	Instructions
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	Claims with a diagnosis code must include the ICD indicator “0”. Claims that do not include the ICD indicator will be returned via the *Resubmission Turnaround Document* (Form 65-1). Medi-Cal requires providers to enter the ICD indicator “0”. **ICD Ind.** Enter the ICD indicator “0” for claims submitted with a date of service on or after October 1, 2015. Claims submitted without a diagnosis code do not require an ICD indicator.
21.A	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.)
21.B	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.)
21.C-L	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Not required by Medi-Cal. Medi-Cal only accepts ____ diagnosis codes. Codes entered in Boxes 21.C-L will not be used for claims processing.
22	RESUBMISSION CODE	Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.
23	PRIOR AUTHORIZATION NUMBER	Physician and podiatry services requiring a *Treatment Authorization Request* (TAR) must enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the Adjudication Response to the claim. For California Children’s Services (CCS) claims, enter the 11-digit Service Authorization Request (SAR) number. **Billing Tip:** Recipient information on the claim must match the _____. Only one TCN can cover the services billed on any one claim.
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.
24B	PLACE OF SERVICE	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered. **Billing Tip:** The national Place of Service codes are listed in the _____ _____ section in the appropriate Part 2 provider manual.

Answer Key: 21.C-L) two, 23) TAR/SAR; 24B) *CMS-1500* Completion

Field Descriptions: 24C – 24J

Box #	Field Name	Instructions
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:** Only one emergency indicator is allowed per claim, and must be placed in the bottom-unshaded portion of Box 24C. Leave this box blank unless billing for emergency services. Enter "X" if an Emergency Certification Statement is attached to claim or entered in Box 19.
24D	PROCEDURES, SERVICES OR SUPPLIES/ MODIFIER	Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s). **Billing Tip:** The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple _____ _____ _____ on the same claim line. If necessary, the procedure description can be entered in the *Additional Claim Information* field (Box 19). **Billing Tip:** 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.
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."
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. **Billing Tip:** Providers billing for units of time should enter the time in _____ _____. 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. **Billing Tip:** 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. **Billing Tip:** If an error has been made to specific billing information entered on items 24A – 24J, draw a line through the entire detail using a blue or black ballpoint pen. Enter the correct billing information on another line. Do not _____ _____ the entire claim line. Deleted information may be used to determine previous payment.

Answer Key: 24D) NCCI associated modifiers; 24G) 15-min. increments; 24J) black out

Field Descriptions: 28 – 33B

Box #	Field Name	Instructions
28	TOTAL CHARGE	Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as “10000.”
29	AMOUNT PAID	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient’s Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($). **Billing Tip:** 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.
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. **Billing Tip:** Signatures must be _____, 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. **Billing Tip:** Use the name and address of the facility where the services were rendered if other than a _____ or _____.
32A	*(blank)*	Enter the NPI of the facility where the services were rendered.
32B	*(blank)*	Enter the Medi-Cal provider number for an atypical service facility.
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.
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. **Billing Tip:** 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.

Answer Key: 31) written; 32) home, office

HEALTH INSURANCE CLAIM FORM

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

PICA | 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 06 DD 21 YY 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? 25000 [X] 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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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 91234567891

	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	16				21		42500	AG		200000	1		NPI	1234567890
2	06	07	16				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 06/30/16

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.

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CARRIER | PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

***CMS-1500* Claim Form with Other Health Coverage.**

NOTE

Claim(s) should be submitted directly to the FI for processing.

Learning Activities

Learning Activity 1: Common Claim Completion Errors

Brainteaser

What is wrong with this claim?

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): 90000000A

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 0123456789

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. 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	15				22		36780			$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.)

SIGNED Polly Ester DATE 06/30/13

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.

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500

Learning Activity 1: Answer Key

Box #	Current Data Entries	Correct Entries
1	Medicare *(checked)*	The Medicaid box should be marked.
1A	90000000A	A 14-digit ID number must be indicated.
2	Luke Out	OUT, LUKE (last name, first, middle initial) The name must be in all caps.
3	(blank)	Recipient's date of birth must be indicated using six-digit (MMDDYY) format.
10D	4.00	Do not use dollar signs or decimals.
17B	(blank)	This field must indicate NPI of referring physician.
21	ICD Ind. (blank)	0
24D	36780	This field requires an appropriate modifier for procedure code.
24F	$62500	Do not use dollar signs or decimals.
27	(blank)	Select "YES" to accept assignment.
29	(blank)	The claim must indicate SOC dollar amount collected (400).
30	62500	Effective for dates of service on or after October 1, 2014, this box is no longer required to be completed.
32	(blank)	Facility name, address and NPI
32A	(blank)	Enter 10-digit NPI number.
33	*(ZIP code missing)*	The nine-digit ZIP code of the billing provider is required without a hyphen.
33A	234567890	Enter the NPI number, which must be 10-digits.

NOTES

Learning Activity 2: Complete It, Submit It, Get Paid

Scenario

The following procedures were performed on June 21, 2016.

Patient Information

Patient (Recipient):	Owen Cash
Birth Date:	August 24, 2007
Address:	123 Summertime Street, Anywhere, CA 98870-4567
Phone Number:	916-123-5555
Medi-Cal Id Number:	90000000A95001

Procedure Information

- Primary Procedure: Plastic repair of cleft lip/nasal deformity, primary bilateral, one-stage procedure
- Secondary Procedure: Tympanostomy (requiring insertion of ventilating tube), also bilateral. Modifier 50 will be billed to identify a bilateral procedure that is more complex and/or requires additional significant time at a single operative session.
- Location Of Service: Outpatient Hospital (22)
- Diagnosis Codes: D1D1D1D (primary) and D2D2D2D (secondary)
- Referring Physician: Dr. Justin Case, NPI# 1234567890

Billing Information

- Primary Procedure: The repair of deformity (primary procedure) will be billed using code 40701 with modifier AG (primary surgeon). As the primary surgery, modifier 50 is not necessary with this code. The usual & customary charge is $4,120.00. Enter a “1” in the *Days/Units* field (Box 24G).
- Multiple Procedures: The tympanostomy will be billed using code 69436 with modifier 51 (multiple procedures). The usual and customary charge is $600.00. Enter a “1” in the *Days/Units* field (Box 24G).
- Bilateral Procedure: The tympanostomy will be billed a second time, with modifier 50 (bilateral procedure) to signify the additional time required, at the usual and customary charge of $600.00. Enter a “1” in the *Days/Units* field (Box 24G).
- Total Charges: $5320.00
- Balance Due: $5320.00
- Signature of Physician/Designee: Polly Ester
  - Biller’s Name/Address: Penny Sillen, MD (916) 555-1234
  - 201 Circle Lane
  - Rio Meadow, CA 98765-3365
  - NPI# 2234566789

NOTE
Always remember to remove dollar signs ($), decimal points (.) and hyphens (-) from ZIP codes when entering data into claim forms.

CMS-1500 Claim Form

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): CASH, OWEN

3. PATIENT'S BIRTH DATE MM 08 DD 24 YY 07 SEX M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 1234 SUMMERTIME ST

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

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

CITY: ANYWHERE STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 988704567 TELEPHONE (Include Area Code): (916) 123-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

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

c. OTHER ACCIDENT? [ ] YES [ ] NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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: JUSTIN CASE MD

17a.

17b. NPI 1234567890

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. 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	21	16				22		40701	AG		412000	1		NPI	
2	06	21	16				22		69436	51		60000	1		NPI	
3	06	21	16				22		69436	50		60000	1		NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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 $ 532000

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 *Polly Ester* DATE 07/01/16

32. SERVICE FACILITY LOCATION INFORMATION
201 CIRCLE LANE
RIO MEADOW, CA 98765-3365

a. 9876543210 b.

33. BILLING PROVIDER INFO & PH # (916) 555-1234
PENNY SILLEN, MD
RIO MEADOW, CA
98765-3365

a. 2234566789 b.

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CMS-1500