

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## CMS-1500 Completion for Vision Care

The *Health Insurance Claim Form (CMS-1500)* is used to bill ophthalmological services and eye appliances to the Medi-Cal program. Because Medi-Cal does not supply the *CMS-1500* claim form, providers are required to purchase their forms from a vendor. Claim forms ordered through vendors must include a sensor block (bar code) and red “drop-out” ink.

Most claims for vision services may also be submitted electronically through the HIPAA-compliant ASC X12N 837 v.5010 transaction. Vision providers may also use the Internet Professional Claims Submission (IPCS) system to submit single claims for processing. For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual. For IPCS information, refer to the Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

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

**Notice:** Claim completion instructions for the new (02/12) version of the *CMS-1500* are included in the first half of this manual section. Claim completion instructions for the previous (08/05) version of the *CMS-1500* are retained in the second half of this section. Claims on the new version will be accepted for processing beginning January 6, 2014. Claims on the old version will be processed through March 31, 2014. Beginning April 1, 2014, only the 02/12 version of the *CMS-1500* will be accepted by Medi-Cal.

### CMS-1500 VERSION 02/12 COMPLETION DIRECTIONS

#### Claim Completion

The 02/12 version of the *CMS-1500* is illustrated on the following page.

#### Differences

At present providers enter exactly the same information in each field as they entered on the previous 08/05 version of the *CMS-1500*, with the following exceptions:

**Box 17:** Data in the *Name of Referring Provider or Other Source* field (Box 17) must be indented. The space to the left of the vertical dotted line must remain blank.

**Box 21:** Data is not required in the *ICD Ind.* area of this box until September 22, 2014.

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

Figure 1: Medi-Cal-Required Fields for Vision Care services. (Sample CMS-1500 version 02/12).

**Explanation of Form Items**

The following item numbers and descriptions correspond to the sample *CMS-1500* claim form 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 use by the DHCS Fiscal Intermediary (FI).

- | <u>Item</u> | <u>Description</u>  |
|-------------|---|
| 1.          | <p><b>MEDICARE/MEDICAID/OTHER ID.</b> If the claim is a Medi-Cal claim, enter an “X” in the Medicaid box. If submitting a Medicare/Medi-Cal claim, use a copy of the original <i>CMS-1500</i> claim form billed to Medicare and enter an “X” in both the <i>Medicaid</i> and <i>Medicare</i> boxes.</p> <p><b>Note:</b> 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><b>INSURED’S ID NUMBER.</b> Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.</p>   |
| 2.          | <p><b>PATIENT’S NAME.</b> Enter the recipient’s last name, first name, middle initial (if known).</p>   |
| 3.          | <p><b>PATIENT’S BIRTH DATE/SEX.</b> Enter the recipient’s date of birth in six-digit MMDDYY (Month, Day, Year) format. Enter an “X” in the “M” or “F” box (as indicated on the BIC). If the recipient’s full date of birth is not available, enter the year preceded by 0101.</p>   |

<u>Item</u>	<u>Description</u>
4.	<p><b>INSURED'S NAME.</b> 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> <p>When submitting a claim for a newborn infant using the mother's ID number and the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl) in Box 2 (Patient's Name) of the <i>CMS-1500</i> claim form.</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.</p>
5.	<p><b>PATIENT'S ADDRESS/TELEPHONE.</b> Enter recipient's complete address and telephone number.</p>
6.	<p><b>PATIENT RELATIONSHIP TO INSURED.</b> 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.</p>
7.	<p><b>INSURED'S ADDRESS.</b> Not required by Medi-Cal.</p>
8.	<p><b>RESERVED FOR NUCC USE.</b> Not required by Medi-Cal.</p>
9.	<p><b>OTHER INSURED'S NAME.</b> Not required by Medi-Cal.</p>
9a.	<p><b>OTHER INSURED'S POLICY OR GROUP NUMBER.</b> Not required by Medi-Cal.</p>
9b.	<p><b>RESERVED FOR NUCC USE.</b> Not required by Medi-Cal.</p>
9c.	<p><b>RESERVED FOR NUCC USE.</b> Not required by Medi-Cal.</p>
9d.	<p><b>INSURANCE PLAN NAME OR PROGRAM NAME.</b> Not required by Medi-Cal.</p>

<u>Item</u>	<u>Description</u>
10.	<b>IS PATIENT'S CONDITION RELATED TO:</b>
10a.	<b>IS PATIENT'S CONDITION RELATED TO EMPLOYMENT.</b> 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 Box 14.
10b.	<b>IS PATIENT'S CONDITION RELATED TO AUTO ACCIDENT/PLACE.</b> Not required by Medi-Cal.
10c.	<b>IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT.</b> Not required by Medi-Cal.
10d.	<b>CLAIM CODES (Designated by NUCC).</b> Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply.
11.	<b>INSURED'S POLICY GROUP OR FECA NUMBER.</b> Not required by Medi-Cal.
11a.	<b>INSURED'S DATE OF BIRTH/SEX.</b> Not required by Medi-Cal.
11b.	<b>OTHER CLAIM ID (Designated by NUCC).</b> Not required by Medi-Cal.
11c.	<b>INSURANCE PLAN NAME OR PROGRAM NAME.</b> For Medicare/Medi-Cal crossover claims. Enter your Medicare Carrier Code.
	<b>Note:</b> Providers may refer to their <i>Medicare Remittance Notice</i> (MRN) for the carrier code to enter in this field.

<u>Item</u>	<u>Description</u>
11d.	<p><b>IS THERE ANOTHER HEALTH BENEFIT PLAN?</b> Enter an “X” in the Yes box if recipient has Other Health Coverage (OHC). If the OHC has paid, enter the amount in the upper right side of this field.</p> <p><b>Note:</b> Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is <u>not</u> considered Other Health Coverage.</p>
12.	<p><b>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE.</b> Not required by Medi-Cal.</p>
13.	<p><b>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE.</b> Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.</p>
14.	<p><b>DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP).</b> Enter the date of onset of the recipient’s illness, the date of accident/injury.</p>
15.	<p><b>OTHER DATE.</b> Not required by Medi-Cal.</p>
16.	<p><b>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.</b> Not required by Medi-Cal.</p>
17.	<p><b>NAME OF REFERRING PROVIDER OR OTHER SOURCE.</b> Indent to the right of the dotted line and enter the name of the referring provider or other source.</p> <p>When billing Optional Benefits Exclusion services for residents of skilled nursing facilities, include the name of the facility in this field.</p>
17a.	<p><b>UNLABELED.</b> Not required by Medi-Cal.</p>
17b.	<p><b>NPI.</b> Enter the NPI for the referring provider or other source.</p> <p>When billing Optional Benefits Exclusion services for residents of skilled nursing facilities, include the NPI of the facility in this field.</p>

- | Item          | Description   |
|---------------|---|
| 18.           | <p><b>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.</b> 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>   |
| 19.           | <p><b>ADDITIONAL CLAIM INFORMATION (Designated by NUCC).</b> Use this area for procedures that require additional information, justification or an Emergency Certification Statement.</p> <p>Refer to the policy sections of this manual for CPT-4/HCPCS codes that require additional justification. If the information requested requires additional space than what is provided in Box 19, include a separate attachment on an 8½ x 11-inch sheet of paper with the claim.</p> <p>If electronically filing a claim with attachments, enter the Attachment Control Number (ACN) from the Attachment Control Form (ACF).</p> |
| 20.           | <p><b>OUTSIDE LAB?</b> 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>  |
| 21.           | <p><b>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A–L to service line below (24E).</b></p> <p><b>ICD Ind.</b> Enter the ICD indicator "9" for claims that will be received by the Fiscal Intermediary on or after September 22, 2014. Claims submitted without a diagnosis code do not require an ICD indicator.</p>   |
| 21.A/<br>21.B | <p><b>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.</b> Enter all letters and/or numbers of the ICD-9-CM code for the <u>primary</u> diagnosis, including fourth and fifth digits, if present.</p> <p><b>Note:</b> For vision services, enter up to two diagnosis codes in Fields 21.A and 21.B. Do not enter more than two diagnosis codes. If billing for multiple procedure codes that require different diagnosis codes than what can be entered in Fields 21.A and 21.B, use a separate claim.</p>   |

- | <u>Item</u>  | <u>Description</u>   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
|--------------|--|-------------|--------------------|---|--|-----|--------------------|-----|---|-----|------------------------|-----|-----------------|-----|-----------------------|-----|------------------------|-----|--|---|----------------------|-----|-------------|-----|---|-----|--|-----|--|
| 21.<br>C – L | <b>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.</b> Not required by Medi-Cal.   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| 22.          | <b>RESUBMISSION CODE/ORIGINAL REF. NO.</b> Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are:<br><table><thead><tr><th><u>Code</u></th><th><u>Explanation</u></th></tr></thead><tbody><tr><td>0</td><td>Younger than 65, does not have Medicare coverage</td></tr><tr><td>1 *</td><td>Benefits exhausted</td></tr><tr><td>2 *</td><td>Utilization committee denial or physician non-certification</td></tr><tr><td>3 *</td><td>No prior hospital stay</td></tr><tr><td>4 *</td><td>Facility denial</td></tr><tr><td>5 *</td><td>Non-eligible provider</td></tr><tr><td>6 *</td><td>Non-eligible recipient</td></tr><tr><td>7 *</td><td>Medicare benefits denied or cut short by Medicare intermediary</td></tr><tr><td>8</td><td>Non-covered services</td></tr><tr><td>9 *</td><td>PSRO denial</td></tr><tr><td>L *</td><td>Medi/Medi Charpentier: Benefit Limitation</td></tr><tr><td>R *</td><td>Medi/Medi Charpentier: Rate Limitation</td></tr><tr><td>T *</td><td>Medi/Medi Charpentier: Both Rates and Benefit Limitation</td></tr></tbody></table> <p>* Documentation is required.</p> | <u>Code</u> | <u>Explanation</u> | 0 | Younger than 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 Limitation | R * | Medi/Medi Charpentier: Rate Limitation | T * | Medi/Medi Charpentier: Both Rates and Benefit Limitation |
| <u>Code</u>  | <u>Explanation</u>   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| 0            | Younger than 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 Limitation  |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| R *          | Medi/Medi Charpentier: Rate Limitation   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| T *          | Medi/Medi Charpentier: Both Rates and Benefit Limitation   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| 23.          | <b>PRIOR AUTHORIZATION NUMBER.</b> For vision care services requiring a <i>Treatment Authorization Request</i> (TAR), enter the 10-digit TAR Control Number followed by the Pricing Indicator (PI) located on the <i>Adjudication Response</i> (AR).   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |

Item      Description

24.1      **CLAIM LINE.** Information for completing a claim line follows in Items 24A – 24J. Refer to the *CMS-1500 Special Billing Instructions for Vision Care* section in this manual for more information.

**Note:** Do not enter data in the shaded area, except for Box 24C.

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.

24B.      **PLACE OF SERVICE.** Enter code indicating where service was rendered.

<u>Code</u>	<u>Place of Service</u>
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility (SNF)
32	Nursing Facility
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
65	End Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service (Describe in <i>Additional Claim Information</i> field [Box 19])

<u>Item</u>	<u>Description</u>
24C.	<p><b>EMG.</b> Emergency or delay reason codes.</p> <p><b>Delay Reason Code:</b> 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> <p><b>Emergency Code:</b> 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 an "X" if an Emergency Certification Statement is attached to this claim or entered in Box 19. The 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><b>PROCEDURES, SERVICES OR SUPPLIES.</b> Enter the applicable procedure code (HCPCS or CPT-4) and a modifier, if required.</p>
24E.	<p><b>DIAGNOSIS POINTER.</b> As required by Medi-Cal.</p>

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<u>Item</u>	<u>Description</u>
24F.	<p><b>CHARGES.</b> In full dollar amount, enter the usual and customary fee for service(s).</p> <p><b>Note:</b> 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>
24G.	<p><b>DAYS OR UNITS.</b> 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><b>Note:</b> Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “4”).</p>
24H.	<p><b>EPSDT FAMILY PLAN.</b> 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.</p>
24I.	<p><b>ID QUALIFIER FOR RENDERING PROVIDER.</b> Not required by Medi-Cal.</p>
24J.	<p><b>RENDERING PROVIDER ID NUMBER.</b> Enter the NPI for rendering provider, if the provider is billing under a group NPI. This applies to all services.</p>

**cms comp vc  
12**

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)		MODIFIER												
1	<del>11</del>	<del>01</del>	<del>05</del>				<del>11</del>		<del>97810</del>	<del>A3</del>		<del>50.00</del>	<del>1</del>		<del>NPI</del>	<del>0123456789</del>	
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.

Item                      Description

24.2 – 24.6    **ADDITIONAL CLAIM LINES.** Follow instructions for each claim line.

<u>Item</u>	<u>Description</u>
25.	<b>FEDERAL TAX I.D. NUMBER.</b> Not required by Medi-Cal.
26.	<b>PATIENT'S ACCOUNT NO.</b> This is an optional field that will help providers to easily identify a recipient on a <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Enter the patient's medical record 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 RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD)</i> completion and <i>Remittance Advice Details (RAD)</i> examples sections in this manual.

- | <u>Item</u> | <u>Description</u>  |
|-------------|---|
| 27.         | <b>ACCEPT ASSIGNMENT.</b> Not required by Medi-Cal.   |
| 28.         | <b>TOTAL CHARGE.</b> Enter the full dollar amount, for all services, without the decimal point (.) or dollar sign (\$). For example, \$100 should be entered as "10000."  |
| 29.         | <b>AMOUNT PAID.</b> Enter the amount of payment received from the Other Health Coverage (Box 11d) and patient's Share of Cost (Box 10d).  |
| 30.         | <b>Rsvd for NUCC USE.</b> Effective September 22, 2014, providers no longer complete this field.  |
| 31.         | <b>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS.</b> The claim must be signed and dated by the provider or a representative assigned by the provider in black ballpoint ink.<br><br>Providers that fill another provider's prescription must keep a copy of the prescription in the recipient's medical record, which must be made available for state review if requested.<br><br><b>Note:</b> Signatures must be written, not printed, and should not extend outside the box. Stamps, initials or facsimiles are not accepted. |
| 32.         | <b>SERVICE FACILITY LOCATION INFORMATION.</b> Not required for vision services.   |

- | Item | Description   |
|------|---|
| 33.  | <b>BILLING PROVIDER INFO AND PHONE NUMBER.</b> Enter the provider name, address, nine-digit ZIP code and telephone number.<br><br><b>Note:</b> The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.  |
| 33a. | Enter the billing provider's NPI.   |
| 33b. | Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.<br><br><b>Note:</b> 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. |

Check Digits

The Department of Health Care Services (DHCS) assigns a check digit to each provider to verify accurate input of the 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 33B. Providers who do not know their check digit should contact the Telephone Service Center (TSC) at 1-800-541-5555.

## CMS-1500 VERSION 08/05 COMPLETION DIRECTIONS

**For Use Through**

**March 31, 2014**

The 08/05 version of the *CMS-1500* is illustrated on the following page.

This version is used for claims processing through March 31, 2014. After that date, Medi-Cal accepts claims for processing only on the *CMS-1500* version 02/12.

This older claim version is missing a field that identifies whether an ICD-9-CM code or ICD-10-CM code is being submitted. In 2014, national claim completion standards changed to require identification of the international classification of diseases version entered on the claim.

**Additional Claim  
Completion Help**

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.

<div style="float: left; border: 1px solid black; padding: 2px;">1500</div> <h2 style="margin: 0;">HEALTH INSURANCE CLAIM FORM</h2> <p style="font-size: small; margin: 0;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>											
<div style="display: flex; justify-content: space-between;"> <span>PICA <input type="checkbox"/></span> <span>PICA <input type="checkbox"/></span> </div>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>MEDI-CAL ID NUMBER</b>					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>PATIENT'S COMPLETE NAME</b>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>MOTHER'S NAME FOR NEWBORN</b>					
5. PATIENT'S ADDRESS (No., Street) <b>PATIENT'S COMPLETE ADDRESS</b>						7. INSURED'S ADDRESS (No., Street)					
CITY <b>PATIENT'S CITY</b>			STATE <b>ST</b>			CITY STATE			CITY STATE		
ZIP CODE <b>PATIENT'S ZIP</b>			TELEPHONE (Include Area Code) <b>(PATIENT'S PHONE</b>			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:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE					
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 <b>NA</b> DATE <b>NA</b>						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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) <b>ONSET DATE</b>				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <b>NA</b> TO <b>NA</b>			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>NAME OF REFERRING PROVIDER</b>						17a. NPI			17b. NPI		
19. RESERVED FOR LOCAL USE <b>ADDITIONAL JUSTIFICATION PLACED HERE</b>						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <b>FROM DOS</b> TO <b>THRU DOS</b>					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>PRIMARY ICD-9 CODE</b> 3. <b>NA</b> 2. <b>SECONDARY ICD-9 CODE</b> 4. <b>NA</b>						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMERG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER						22. MEDICAID RESUBMISSION CODE <b>RESUBMIT CODE</b> ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER <b>TAR CONTROL NUMBER</b>					
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						28. TOTAL CHARGE \$ <b>TOTAL CHARGES</b>					
26. PATIENT'S ACCOUNT NO. <b>PATIENT ACCOUNT NUMBER</b>						29. AMOUNT PAID \$ <b>TOTAL DEDUCTIONS</b>					
27. ACCEPT ASSIGNMENT? (If gov. assign, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						30. BALANCE DUE \$ <b>NET BILLED</b>					
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.) <b>SIGNATURE OF PROVIDER OR PERSON AUTHORIZED</b> SIGNED DATE						32. SERVICE FACILITY LOCATION INFORMATION <b>NAME AND ADDRESS OF SERVICE FACILITY</b> a. <b>FACILITY NPI</b> b. <b>NON-NPI NUMBER</b>					
33. BILLING PROVIDER INFO & PH # <b>BILLER ADDRESS</b> a. <b>BILLER NPI</b> b. <b>NON-NPI NUMBER</b>						34. <b>NON-NPI NUMBER</b>					

Figure 3: Medi-Cal-Required Fields for Vision Care services. (Sample CMS-1500 version 08/05).

**Explanation of Form Items**

The following item numbers and descriptions correspond to the sample *CMS-1500* claim form 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 use by the DHCS Fiscal Intermediary (FI).

Item      Description

1.      **MEDICARE/MEDICAID/OTHER ID.** If the claim is a Medi-Cal claim, enter an “X” in the Medicaid box. If submitting a Medicare/Medi-Cal claim, use a copy of the original *CMS-1500* claim form billed to Medicare and enter an “X” in both the *Medicaid* and *Medicare* boxes.

**Note:** For more information about crossover claims, refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.

1A.     **INSURED’S ID NUMBER.** Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

2.      **PATIENT’S NAME.** Enter the recipient’s last name, first name, middle initial (if known).

3.      **PATIENT’S BIRTH DATE/SEX.** Enter the recipient’s date of birth in six-digit MMDDYY (Month, Day, Year) format. Enter an “X” in the “M” or “F” box (as indicated on the BIC).

<u>Item</u>	<u>Description</u>
4.	<p><b>INSURED'S NAME.</b> 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> <p>When submitting a claim for a newborn infant using the mother's ID number and the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones, Baby Girl) in Box 2 (Patient's Name) of the <i>CMS-1500</i> claim form.</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.</p>
5.	<p><b>PATIENT'S ADDRESS/TELEPHONE.</b> Enter recipient's complete address and telephone number.</p>
6.	<p><b>PATIENT RELATIONSHIP TO INSURED.</b> 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.</p>
7.	<p><b>INSURED'S ADDRESS.</b> Not required by Medi-Cal.</p>
8.	<p><b>PATIENT STATUS.</b> Not required by Medi-Cal.</p>
9.	<p><b>OTHER INSURED'S NAME.</b> Not required by Medi-Cal.</p>
9A.	<p><b>OTHER INSURED'S POLICY OR GROUP NUMBER.</b> Not required by Medi-Cal.</p>
9B.	<p><b>OTHER INSURED'S DATE OF BIRTH.</b> Not required by Medi-Cal.</p>
9C.	<p><b>EMPLOYER'S NAME OR SCHOOL NAME.</b> Not required by Medi-Cal.</p>
9D.	<p><b>INSURANCE PLAN NAME OR PROGRAM NAME.</b> Not required by Medi-Cal.</p>

<u>Item</u>	<u>Description</u>
10A.	<b>IS PATIENT'S CONDITION RELATED TO EMPLOYMENT.</b> 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 Box 14.
10B.	<b>IS PATIENT'S CONDITION RELATED TO AUTO ACCIDENT/PLACE.</b> Not required by Medi-Cal.
10C.	<b>IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT.</b> Not required by Medi-Cal.
10D.	<b>RESERVED FOR LOCAL USE (Share of Cost).</b> Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply.
11.	<b>INSURED'S POLICY GROUP OR FECA NUMBER.</b> Not required by Medi-Cal.
11A.	<b>INSURED'S DATE OF BIRTH/SEX.</b> Not required by Medi-Cal.
11B.	<b>EMPLOYER'S NAME OR SCHOOL NAME.</b> Not required by Medi-Cal.
11C.	<b>INSURANCE PLAN NAME OR PROGRAM NAME.</b> For Medicare/Medi-Cal crossover claims. Enter your Medicare Carrier Code.  <b>Note:</b> Providers may refer to their <i>Medicare Remittance Notice</i> (MRN) for the carrier code to enter in this field.

- 
- | <u>Item</u> | <u>Description</u>  |
|-------------|---|
| 11D.        | <p><b>IS THERE ANOTHER HEALTH BENEFIT PLAN?</b> Enter an “X” in the Yes box if recipient has Other Health Coverage (OHC). If the OHC has paid, enter the amount in the upper right side of this field.</p> <p><b>Note:</b> Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is <u>not</u> considered Other Health Coverage.</p> |
| 12.         | <p><b>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE.</b><br/>Not required by Medi-Cal.</p>   |
| 13.         | <p><b>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE.</b><br/>Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.</p>   |
| 14.         | <p><b>DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP).</b> Enter the date of onset of the recipient’s illness, the date of accident/injury.</p>  |
| 15.         | <p><b>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE.</b> Not required by Medi-Cal.</p>  |
| 16.         | <p><b>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.</b> Not required by Medi-Cal.</p>   |
| 17.         | <p><b>NAME OF REFERRING PROVIDER OR OTHER SOURCE.</b><br/>Enter the name of the referring provider or other source.</p> <p>When billing Optional Benefits Exclusion services for residents of skilled nursing facilities, include the name of the facility in this field.</p>   |
| 17A.        | <p><b>UNLABELED.</b> Not required by Medi-Cal.</p>  |
| 17B.        | <p><b>NPI.</b> Enter the NPI for the referring provider or other source.</p> <p>When billing Optional Benefits Exclusion services for residents of skilled nursing facilities, include the NPI of the facility in this field.</p>   |

- | <u>Item</u> | <u>Description</u>  |
|-------------|---|
| 18.         | <b>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.</b> 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.         | <b>RESERVED FOR LOCAL USE.</b> Use this area for procedures that require additional information, justification or an Emergency Certification Statement.<br><br>Refer to the policy sections of this manual for CPT-4/HCPCS codes that require additional justification. If the information requested requires additional space than what is provided in Box 19, include a separate attachment on an 8½ x 11-inch sheet of paper with the claim.<br><br>If electronically filing a claim with attachments, enter the Attachment Control Number (ACN) from the Attachment Control Form (ACF). |
| 20.         | <b>OUTSIDE LAB?</b> 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.   |
| 21.         | <b>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.</b> Enter all letters and/or numbers of the ICD-9-CM code for the <u>primary</u> diagnosis, including fourth and fifth digits, if present.<br><br><b>Note:</b> For vision services, enter up to two diagnosis codes in Fields 21.1 and 21.2. Do not enter more than two diagnosis codes. If billing for multiple procedure codes that require different diagnosis codes than what can be entered in Fields 21.1 and 21.2, use a separate claim.  |

- 
- | <u>Item</u> | <u>Description</u>   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
|-------------|--|-------------|--------------------|---|--|-----|--------------------|-----|---|-----|------------------------|-----|-----------------|-----|-----------------------|-----|------------------------|-----|--|---|----------------------|-----|-------------|-----|---|-----|--|-----|--|
| 22.         | <p><b>MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.</b><br/>Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.</p> <table border="0"> <thead> <tr> <th style="text-align: left;"><u>Code</u></th> <th style="text-align: left;"><u>Explanation</u></th> </tr> </thead> <tbody> <tr> <td>0</td> <td>Younger than 65, does not have Medicare coverage</td> </tr> <tr> <td>1 *</td> <td>Benefits exhausted</td> </tr> <tr> <td>2 *</td> <td>Utilization committee denial or physician non-certification</td> </tr> <tr> <td>3 *</td> <td>No prior hospital stay</td> </tr> <tr> <td>4 *</td> <td>Facility denial</td> </tr> <tr> <td>5 *</td> <td>Non-eligible provider</td> </tr> <tr> <td>6 *</td> <td>Non-eligible recipient</td> </tr> <tr> <td>7 *</td> <td>Medicare benefits denied or cut short by Medicare intermediary</td> </tr> <tr> <td>8</td> <td>Non-covered services</td> </tr> <tr> <td>9 *</td> <td>PSRO denial</td> </tr> <tr> <td>L *</td> <td>Medi/Medi Charpentier: Benefit Limitation</td> </tr> <tr> <td>R *</td> <td>Medi/Medi Charpentier: Rate Limitation</td> </tr> <tr> <td>T *</td> <td>Medi/Medi Charpentier: Both Rates and Benefit Limitation</td> </tr> </tbody> </table> <p>* Documentation is required.</p> | <u>Code</u> | <u>Explanation</u> | 0 | Younger than 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 Limitation | R * | Medi/Medi Charpentier: Rate Limitation | T * | Medi/Medi Charpentier: Both Rates and Benefit Limitation |
| <u>Code</u> | <u>Explanation</u>   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| 0           | Younger than 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 Limitation  |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| R *         | Medi/Medi Charpentier: Rate Limitation   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| T *         | Medi/Medi Charpentier: Both Rates and Benefit Limitation   |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |
| 23.         | <p><b>PRIOR AUTHORIZATION NUMBER.</b> For Vision care services requiring a <i>Treatment Authorization Request</i> (TAR), enter the 10-digit TAR Control Number followed by the Pricing Indicator (PI) located on the <i>Adjudication Response</i> (AR).</p>  |             |                    |   |  |     |                    |     |   |     |                        |     |                 |     |                       |     |                        |     |  |   |                      |     |             |     |   |     |  |     |  |

Item      Description

24.1      **CLAIM LINE.** Information for completing a claim line follows in Items 24A – 24J. Refer to the *CMS-1500 Special Billing Instructions for Vision Care* section in this manual for more information.

**Note:** Do not enter data in the shaded area, except for Box 24C.

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.

24B.      **PLACE OF SERVICE.** Enter code indicating where service was rendered.

<u>Code</u>	<u>Place of Service</u>
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility (SNF)
32	Nursing Facility
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
65	End Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service (Describe in <i>Reserved for Local Use</i> field [Box 19])

<u>Item</u>	<u>Description</u>
24C.	<p><b>EMG.</b> Emergency or delay reason codes.</p> <p><b>Delay Reason Code:</b> 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> <p><b>Emergency Code:</b> 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 an "X" if an Emergency Certification Statement is attached to this claim or entered in Box 19. The 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><b>PROCEDURES, SERVICES OR SUPPLIES.</b> Enter the applicable procedure code (HCPCS or CPT-4) and a modifier, if required.</p>
24E.	<p><b>DIAGNOSIS POINTER.</b> As required by Medi-Cal.</p>

<u>Item</u>	<u>Description</u>
24F.	<p><b>CHARGES.</b> In full dollar amount, enter the usual and customary fee for service(s).</p> <p><b>Note:</b> 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>
24G.	<p><b>DAYS OR UNITS.</b> 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><b>Note:</b> Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “4”).</p>
24H.	<p><b>EPSDT FAMILY PLAN.</b> 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.</p>
24I.	<p><b>ID QUALIFIER FOR RENDERING PROVIDER.</b> Not required by Medi-Cal.</p>
24J.	<p><b>RENDERING PROVIDER ID NUMBER.</b> Enter the NPI for rendering provider, if the provider is billing under a group NPI.</p> <p>The rendering provider instructions apply to services rendered by the following providers:</p> <ul style="list-style-type: none"><li>• Optometrists</li><li>• Ophthalmologists</li></ul>

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	To							(Explain Unusual Circumstances)								
MM	DD	YY	MM	DD	YY			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 4. Sample of Deleted Information.

Item                      Description

24.2 – 24.6 **ADDITIONAL CLAIM LINES.** Follow instructions for each claim line.

<u>Item</u>	<u>Description</u>
25.	<b>FEDERAL TAX I.D. NUMBER.</b> Not required by Medi-Cal.
26.	<b>PATIENT'S ACCOUNT NO.</b> This is an optional field that will help providers to easily identify a recipient on a <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Enter the patient's medical record 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 RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD)</i> completion and <i>Remittance Advice Details (RAD)</i> examples sections in this manual.

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- | <u>Item</u> | <u>Description</u>  |
|-------------|---|
| 27.         | <b>ACCEPT ASSIGNMENT.</b> Not required by Medi-Cal.   |
| 28.         | <b>TOTAL CHARGE.</b> Enter the full dollar amount, for all services, without the decimal point (.) or dollar sign (\$). For example, \$100 should be entered as "10000."  |
| 29.         | <b>AMOUNT PAID.</b> Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D).  |
| 30.         | <b>BALANCE DUE.</b> Enter the difference between <i>Total Charges</i> and <i>Amount Paid</i> .  |
| 31.         | <b>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS.</b> The claim must be signed and dated by the provider or a representative assigned by the provider in black ballpoint ink.<br><br>Providers that fill another provider's prescription must keep a copy of the prescription in the recipient's medical record, which must be made available for state review if requested.<br><br><b>Note:</b> Signatures must be written, not printed, and should not extend outside the box. Stamps, initials or facsimiles are not accepted. |
| 32.         | <b>SERVICE FACILITY LOCATION INFORMATION.</b> Not required for vision services.   |

- | <u>Item</u> | <u>Description</u>   |
|-------------|--|
| 34.         | <p><b>BILLING PROVIDER INFO AND PHONE NUMBER.</b> Enter the provider name, address, nine-digit ZIP code and telephone number.</p> <p><b>Note:</b> 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.        | <p>Enter the billing provider's NPI.</p>   |
| 33B.        | <p>Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.</p> <p><b>Note:</b> 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

The Department of Health Care Services (DHCS) assigns a check digit to each provider to verify accurate input of the 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 33B. Providers who do not know their check digit should contact the Telephone Service Center (TSC) at 1-800-541-5555.