CHAPTER 8:

Billing on the CMS 1500 Claim Form

Reviewed/Revised: 01/01/24

8.0 INTRODUCTION

The CMS 1500 claim form is used to bill for non-facility services, including professional services, freestanding surgery centers, transportation, durable medical equipment, ambulatory surgery centers and independent laboratories. This chapter covers paper claim submission only, for additional information on electronic claim submission and general billing requirements please see Chapter 7 *General Billing Rules*.

The information is provided "as is" without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All models, methodologies and guidelines are undergoing continuous improvement and modification by Noridian Healthcare Solutions (Noridian) and the CMS. The most current edition of the information contained can be found on the Noridian website and the CMS website.

8.1 SUCCESSFUL CMS 1500 CLAIM SUBMISSION TIPS

Format:

- Do not print, hand-write, or stamp any extraneous data on the form.
- No hand-written corrections, no highlighting.
- Enter all information on the same horizontal plane within the designated field.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Use individual's name in provider signature, not a facility or practice name.
- If required fields are not completed or if any fields are completed incorrectly, an error code will be identified for the claim. For example, if the date is "December 10, 2016" it must be recorded as 12/10/2016 (MM/DD/YYYY format).

Accurate information is key:

- Put member's name and ID number as it appears on member card
- Include all applicable NPI numbers
- Indicate the correct address including ZIP code where service was rendered,
- Ensure that the # of units/days and the dates of service range are not contradictory
- Ensure that the quantity indicated in the procedure codes description are not contradictory
- If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456).

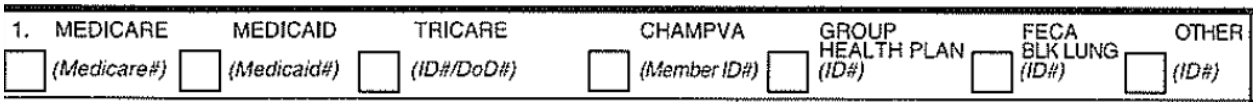
Coding tips:

- Assign current ICD-10 diagnosis codes and code them to the highest level of specificity available.
    - Primary diagnosis (The primary diagnosis should describe the main condition or symptom of the patient).
    - Secondary/Additional Diagnosis
        - ✓ This field should be used if there is a secondary and/or additional conditions or symptoms that affect the treatment.
        - ✓ Diagnosis which relate to a previous illness and which have no bearing on the current encounter should not be reported.
- The number of anesthesia minutes should always be reported on each claim in Field 24G.
- Use current valid CPT and HCPCS codes.
- Use current valid modifiers when necessary.

8.2 COMPLETING THE CMS 1500 CLAIM FORM

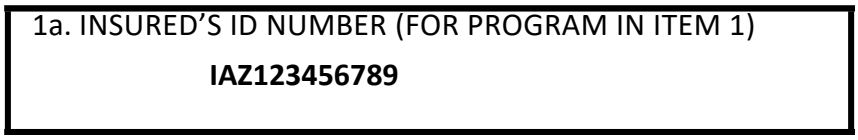
The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

1. Program Block **Required**



1a. Insured's ID Number **Required**

Enter the recipient's ACA StandardHealth with Health Choice ID number. If there are questions about eligibility or the ACA StandardHealth with Health Choice ID number, review eligibility via the BCBSAZ Health Choice Provider Portal, or contact BCBSAZ Health Choice at (800) 322-8670 (see Chapter 2: Member Eligibility and Member Services for additional guidance).



2. Patient's Name **Required**

Enter recipient's last name, first name, and middle initial as shown on the ACA StandardHealth with Health Choice ID card.

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

3. Patient's Date of Birth and Sex **Date of Birth is Required**
Sex is Required if applicable

Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY		
08	14	1851	M ☒	F ☐

4. Insured's Name **Not Required**

5. Patient Address **Not Required**

6. Patient Relationship to Insured **Not Required**

7. Insured's Address **Not Required**

8. Reserved for NUCC Use **Not Required**

9. Other Insured's Name **Required if applicable**

If the recipient has no coverage other than ACA StandardHealth with Health Choice, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group **Required if applicable**

Enter the group number of the other insurance.

9b. Reserved for NUCC Use **Not Required**

9c. Reserved for NUCC Use **Not Required**

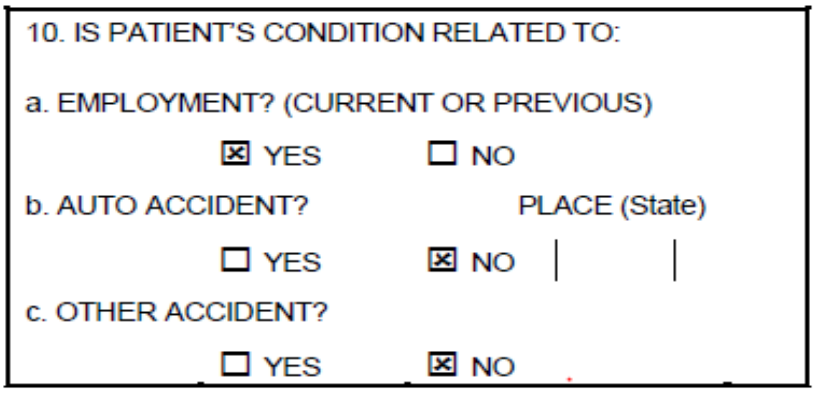
9d. Insurance Plan Name or Program Name **Required if applicable**

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient's Condition Related to: **Required if applicable**

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter

the two-letter abbreviation of the state in which the person responsible for the accident is insured.



10d. Claim Codes (Designated by NUCC) **Not Required**

11. Insured's Group Policy or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

11b. Other Claim ID (Designated by NUCC) **Not Required**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**
Check the appropriate box to indicate coverage other than ACA StandardHealth with Health Choice. If "Yes" is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Required**
If the signature is on file, then stating that the signature is on file is acceptable.

13. Insured's or Authorized Person's Signature **Required if applicable**

14. Date of Illness, Injury, or Pregnancy (LMP) **Required if applicable**

15. Other Date **Not Required**

16. Dates Patient Unable to Work in Current Occupation **Not Required**

17. Qualifier / Name of Provider or Other Source **Required if applicable**
If applicable, enter the Qualifier:

DN Referring Provider
DK Ordering Provider*****
DQ Supervising Provider

Then enter the Name of the Provider or Other Source

***** The ordering provider is *required* for:

- Laboratory
- Radiology
- Medical and Surgical Supplies
- Respiratory DME
- Enteral and Parenteral Therapy
- Durable Medical Equipment
- Drugs (J-codes)
- Temporary K codes
- Orthotics
- Prosthetics
- Temporary Q codes
- Vision codes (V-codes)
- 97001-97546

Ordering providers can be a M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

17a. ID Number of Provider **Required if applicable**

17b. NPI # of Referring Provider **Required**

18. Hospitalization Dates Related to Current Services **Not Required**

19. Additional Claim Information **Required if applicable**

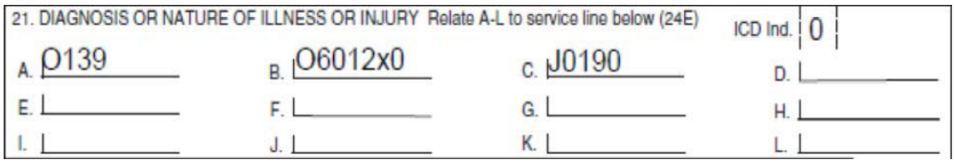
Any additional information required for the processing of a claim (that is not found in another field) shall be entered under the Additional Claim Information field.

20. Outside Lab and ($) Charges **Not Required**

21. Diagnosis Codes **Required**

Enter at least one *ICD-10 diagnosis code* describing the recipient's condition. Diagnosis codes are required to the $6^{th}/7^{th}$ character level when applicable. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

Health providers must **not** use DSM-4 diagnosis codes



22. Medicaid Resubmission Code **Required if applicable**

Enter the appropriate code "A" (paper) "7" for adjustment or "8" for void to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the ACA StandardHealth with Health Choice

Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No." See Chapter 7: *General Billing Rules*, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
A	**030010004321**

23. Prior Authorization Number **Not Required**

If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456). See Chapter 6: *Authorizations and Notifications*, for information on prior authorization.

24A. Date(s) of Service and NDC (effective 7/1/12) **Required/NDC if applicable**

- In Field 24A of the CMS-1500 Form in the shaded area, enter the **NDC Qualifier** of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then,
- A space and the NDC Units of Measure Qualifier, followed by the NDC Quantity.
- All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column **G** (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

24. A		B	C	D	
DATE(S) OF SERVICE		Place		PROCEDURE, SERVICES, OR SUPPLIES	
From	To	of		(Explain Unusual Circumstances)	
M DD YY	M DD YY	Service	EMG	CPT/HCPCS	MODIFIER
N400074115278 ML10					
07 01 12	07 01 12	11		J1642	

The beginning and ending service dates must be entered in the non-shaded area.

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

01	Pharmacy	19	Off Campus-Outpatient Hospital	49	Independent Clinic
02	TeleHealth	20	Urgent Care Facility	50	FQHC
03	School	21	Inpatient Hospital	51	Inpatient Psychiatric Facility
04	Homeless shelter	23	ER - Hospital	54	ICF/Mentally Retarded

05	IHS Free-standing Facility	24	ASC	55	Residential Substance Abuse Treat Facility
06	IHS Provider-based	25	Birthing Center	56	Psych Residential Treatment
07	Tribal 638 Free-standing Facility	26	Military Treatment Facility	57	Non-residential Substance Abuse Treatment Facility
08	Tribal 638 Provider-based Facility	31	Skilled Nursing Facility	60	Mass Immunization Center
11	Office	32	Nursing Facility	61	Comprehensive Inpatient Rehabilitation Facility
12	Home	33	Custodial Care Facility	62	Comprehensive Outpatient Rehabilitation Facility
13	Assisted Living Facility	34	Hospice	65	ESRD Treatment Facility
		41	Ambulance – Land	71	State or Local Public Health Clinic
14	Group Home	42	Ambulance – Air or Water	72	Rural Health Clinic
99	Other Place of Service			81	Independent Laboratory

24. A						B	C	D	
DATE(S) OF SERVICE						Place of		PROCEDURE, SERVICES, OR SUPPLIES	
From			To						
MM	DD	YY	MM	DD	YY	Service	EMG	CPT/HCPCS	MODIFIER
						11			

24C.EMG- Emergency Indicator **Required if applicable**

Mark this box with a "Y" if the service was an emergency service, regardless of where it was provided.

24. A						B	C	D	
DATE(S) OF SERVICE						Place of		PROCEDURE, SERVICES, OR SUPPLIES	
Fro			To						
MM	DD	YY	MM	DD	YY	Service	EMG	CPT/HCPCS	MODIFIER
							Y		

24D. Procedure and Procedure Modifier **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment. The modifier field allows for four sets of 2 characters

24. A		B	C	D	
DATE(S) OF From MM DD YY	To MM DD YY	Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER
				71010	**26**

24E. Diagnosis Pointer **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance. **To avoid claim denials, ensure the diagnosis code referenced in this field has a direct relationship to the CPT/HCPC code billed.**

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
		1			
		1, 2			

24F. Charges $ **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D		E	F		G	H
PROCEDURE, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan
			150	**00**		
			79	**00**		

24G. Days or Units **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES					
CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
				2	
				1	

24H. EPSDT/Family Planning **Not Required**

24I. ID Qualifier **Required if applicable**

24J. Rendering Provider ID Number **Required**

(SHADED AREA) – Use for Taxonomy Code **Required if applicable**
Use this SHADED field to report the provider's 10 digit alpha-numeric Taxonomy Number.
NOTE: Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer's EOB to the claim.

See Chapter 14 *Medicare and Other Insurance Liability* for details on billing claims with Medicare and other insurance.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID # **Required**
Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI number.

. The provider number is required in 24J if the NPI listed in 33A is not the same as the provider rendering services.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
					NPI Rendering Provider NPI

25. Federal Tax **Required**
Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	☐	x	

26. Patient Account Number **Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. ACA StandardHealth with Health Choice

will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the ACA StandardHealth with Health Choice

CRN and the provider's own accounting or tracking system.

27. Accept Assignment **Not Required**

28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? (For govt claims, see back) YES NO	28. TOTAL CHARGE		29. AMOUNT PAID	30. Rsvd for NUCC Use
	$ **179**	**00**	$	$

When submitting a claim with multiple pages (a multi-page claim) **all lines must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.)

Multi-page claims should have the total charges field left blank. The total charges should *only be entered on the last page of a multi-page claim.*

29. Amount Paid **Required if applicable**

Enter the total amount that the provider has been paid for this claim by all sources *other than*

ACA StandardHealth with Health Choice

Do *not* enter any amounts expected to be paid by ACA StandardHealth with Health Choice

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30. Reserved for NUCC Use **Not Required**

31. Signature and Date **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS

(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED **John Doe** DATE **03/01/03**

32. Name and Address of Facility **Required if applicable**

If the pay to address and the service address are the same, then box 32 is not required unless the rendering provider has multiple locations under the same TIN# then box 32 is required. **Box 32 CANNOT contain a post office box address; it must be a physical address.**

32. SERVICE FACILITY LOCATION INFORMATION

Arizona Hospital
123 Main Street Scottsdale, AZ 85252 a. NPI | b

32a. Service Facility NPI **Required if applicable**

If the service facility location is indicated, service facility NPI# must be entered.

32b. Service Facility ID# (Shaded area) **Required if applicable**

33. Billing Provider Name, Address and Phone Number **Required**

Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI Number **Required if applicable**

33b. Other ID –# (Shaded area) **Required if applicable**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

Doc Holliday
123 OK Corral Drive
Tombstone, AZ 85999

a. NPI	b. Taxonomy Code

**** Note – NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, box 33b must be completed.**