Completing the CMS-1500 Version 08/05 Claim Form Guidelines for Physician Providers

(Revised October 2006)

Medica follows national and state uniform billing guidelines for the submission of CMS-1500 claim forms, although some fields required by Medicare or other payers may not be necessary for Medica claims. Following, on page 2, is a blank CMS-1500 claim form for reference, and pages 3-6 contain Medica's requirements for successful completion of the CMS-1500 form by professional providers. These instructions include specifications for each form locator (field) on the CMS-1500 claim form and whether or not Medica requires the field be completed for professional claims. The chart of instructions uses color to communicate whether filling in each field on the CMS-1500 claim form is required, not required, required when applicable, or desirable when completing a Medica claim.

Service

The Provider Service Center is the first point of contact for providers in regards to eligibility inquiries, benefit determination questions and claim status issues. Provider service representatives are available Monday through Thursday from 8:30 a.m. to 5 p.m., and Friday from 9 a.m. to 5 p.m.

Medica Provider Service Center phone numbers

Provider Service Center:
1-800-458-5512

Literature Request Line:
952-992-2355 or 1-800-458-5512, option 8, ext. 2-2355, outside Twin Cities metro area.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____　　3. ____ . ____

2. ____ . ____　　4. ____ . ____

22. MEDICAID 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. BALANCE DUE $

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

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

R	Required
RA	Required if applicable
O	Optional

	Field No.	Field Name	Instructions
O	1	Type of insurance	Indicate the type of health insurance applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
R	1a	Insured's ID number	Enter insured's 9-digit Medica ID number as show on insured's Medica ID card.
R	2	Patient's name	Last name, first name, middle initial.
R	3	Patient's date of birth; sex	Enter patient's Date of Birth in month, day, year (e.g. January 10, 1939 = 01 10 1939); enter an X in the correct box to indicate sex of patient.
R	4	Insured's name	Last name, first name, middle name.
RA	5	Patient's address	Complete if different than insured's address as indicated in Box 7.
R	6	Patient relationship to insured	Place an X in box for "self" if the patient is the insured; or "spouse" if the patient is the insured's husband or wife; or "child" if the patient is the insured's child. Use "other" if none of the above is applicable.
R	7	Insured's address	House number, street, city, state (two-letter abbreviation), ZIP code, telephone number (including area code).
R	8	Patient status	Enter an X in the appropriate boxes. If the patient is a full-time student, complete box 11.
RA	9	Other insured's name	If "yes" checked in Box 11d indicating there is secondary insurance coverage, this box must be completed with other insurance name.
RA	9a	Other insured's policy or group number	If "yes" checked in Box 11d indicating there is secondary insurance coverage, this box must be completed with other insurance ID number.
RA	9b	Other insured's date of birth	If "yes" checked in Box 11d indicating there is secondary insurance coverage, this box must be completed with other insured's date of birth.
RA	9c	Employers name or school name	If "yes" checked in Box 11d indicating there is secondary insurance coverage, this box must be completed with other insurance employer or school name.
RA	9d	Insurance plan name or program name	If "yes" checked in Box 11d indicating there is secondary insurance coverage, this box must be completed with other insurance carrier name.
RA	10a, b, c	Is patient's condition related to:	Enter an X in the correct box to indicate whether one or more of the services described in box 24 are for a condition or injury that occurred on the job or as a result of an auto or other accident.

R	Required
RA	Required if applicable
O	Optional

	Field No.	Field Name	Instructions
O	10d	Reserved for local use	Medica does not use, leave blank.
R	11	Insured's policy, group or FECA number	Insured's 5 or 6-digit group number from Medica ID card.
R	11a	Insured's date of birth; sex	Enter insured's Date of Birth in month, day, year (e.g. January 10, 1939 = 01 10 1939); enter an X in the correct box to indicate sex of insured.
RA	11b	Employer's name or school name	Complete if full-time student.
RA	11c	Insurance plan name or program name	Enter the insurance plan or program name of the insured.
RA	11d	Is there another health benefit plan?	If applicable, enter an X in the correct box. If "Yes" checked, 9a-d must be completed.
R	12	Patient or authorized person's signature	Enter "Signature on File" or legal signature.
O	13	Insured's or authorized person's signature	Enter "Signature on File" or legal signature.
RA	14	Date of current illness, injury, pregnancy	Required if injury or emergency. Enter the 6-digit (MMDDYY) date.
RA	15	If Patient has had same or similar illness	Date first seen for this condition.
O	16	Dates patient unable to work in current occupation	Dates patient is unable to work in current occupation.
RA	17	Name of referring physician or other source	Enter the name (first name, middle initial, last name) and credentials of the professional who referred or ordered the services/supplies on claim.
RA	17a	Other ID #	Enter the referring provider's 7-digit provider number.
RA	17b	NPI #	Enter the referring provider's NPI number.
O	18	Hospitalization dates related to current services	If any services occurred during an inpatient hospital or extended care facility stay, enter admit and discharge dates (e.g. February 11, 1999 – February 13, 1999 = 02 11 99 02 13 99)
O	19	Reserved for local use	Medica does not use, leave blank.
O	20	Outside lab?	Complete this field if billing for purchased services.

R	Required
RA	Required if applicable
O	Optional

	Field No.	Field Name	Instructions
R	21	Diagnosis or nature of illness or injury	Enter the patient's diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Use the highest level of specificity – do not include a narrative.
O	22	Medicaid resubmission	List the original reference number for resubmitted claims.
O	23	Prior authorization number	Submit authorization code when applicable.
R	24a	Date(s) of service	List one date of service per line (e.g. April 29, 1974 = 04 29 74)
RA	24a (shaded portion)	Date(s) of service	EPSDT two-digit referral codes, if applicable. Required if Box 24h completed.
R	24b	Place of service	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.
O	24c	EMG	Emergency indicator. Medica does not require.
R	24d	Procedures, services or supplies	Enter the CPT or HCPCS code(s) and modifiers (if applicable) from the appropriate code set in effect on the date of service. Do not show narrative.
R	24e	Diagnosis pointer	Enter the diagnosis code reference number (pointer) as shown in field 21 to relate the date of service and the procedures performed to the primary diagnosis.
R	24f	Charges	Fill in the amount for each line on the claim. This should be the original charge. Do not indicate balance due, patient liability, late charges/credits or zero dollar claims. Do not use decimals or dollar signs.
R	24g	Days or units	Enter the number of days or units being charged on this line of service. If only one service was performed enter a 1.
RA	24h	EPSDT, family planning	If the claim is for EPSDT, enter a "Y" for yes in the non-shaded portion of this box for each line of EPSDT service. The appropriate referral code should be entered in the shaded area of Box 24A.
O	24i	ID qualifier	Medica does not use this field, leave blank.
RA	24j	Rendering provider ID	Enter Type I NPI
R	25	Federal tax ID number	Enter the provider of service or supplier federal tax ID (employer identification number). If not available enter your social security number. Enter an X in the appropriate box to indicate which number is being reported.

R	Required
RA	Required if applicable
O	Optional

	Field No.	Field Name	Instructions
O	26	Patient's account no.	Enter the patient's account number assigned by the provider of service's or supplier's accounting system. If you include a number it will be reported on the Provider Remittance Advice or Provider Explanation of Benefits.
RA	27	Accept assignment?	Enter an X in the correct box. Only one box can be marked.
R	28	Total charge	Enter total charge for the services (i.e. total of all charges in 24f).
RA	29	Amount paid	Enter the patient's primary carrier's payment amount if Medicare was not the primary payer. If Medicare was the primary payer, an EOMB will be necessary.
RA	30	Balance due	Enter total amount due.
R	31	Signature of physician or supplier including degrees or credentials	Enter "Signature on file" or the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative.
R	32	Service facility location information	Enter the name, address, city, state and zip code of the location where the services were rendered. When more than one supplier is used, a separate claim form should be used to bill for each supplier.
RA	32a	NPI #	Medica does not currently recognize this field.
O	32b	Other ID #	Medica does not currently recognize this field.
R	33	Billing provider info and phone #	Enter the provider or supplier's billing name, address, zip code and phone number in the following format: Line 1 – name of physician or clinic Line 2 – street address Line 3 – city, state, zip code
RA	33a	NPI #	Enter Type II NPI
O	33b	Other ID #	Enter the servicing provider's 7-digit Medica provider number.