CMS-1500 Workshop

Presented by
Mina Reynaga
Provider Field Representative

ACS
A xerox Company

ACS Helpdesks

Call 505-246-0710 or 800-299-7304 - to directly reach all provider help desks including Provider Relations, Provider Enrollment, the HIPAA/EMC help desk and TPL.

ACS Info

For all contact, Claims, and Correspondence Addresses information go to the following link on the New Mexico Medicaid Web Portal:

- https://nmmedicaid.acs-inc.com/nm/general/loadstatic.do?page=ContactUs.htm

ACS
A xerox Company

Important State Websites

STATE WEBSITE:

PROGRAM POLICY MANUAL

- http://www.hsd.state.nm.us/mad/policymanual.html

BILLING INSTRUCTIONS

- http://www.hsd.state.nm.us/mad/billinginstructions.html

REGISTERS AND SUPPLEMENTS:

- http://www.hsd.state.nm.us/mad/registers/

ACS Field Representatives

Provider Field Representative:

Mina Reynaga- (505) 246-9988 Ext. 223; (800) 282-4477 Ext 223

- E-mail: Erminia.Reynaga@acs-inc.com

IMPORTANT UPDATE!
Electronic Funds Transfers (EFT)

As of May 1, Medical Assistance Division policy requires payment to be made only via electronic funds transfer (EFT). As stated in section 8.302.2.9, "MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made." (Please see Program Policy Manual)

IMPORTANT UPDATE!
Electronic Funds Transfers (EFT)

ELECTRONIC FUNDS TRANSFER
HUNDREDS OF PROVIDERS HAVE SIGNED UP!

PLEASE GO TO 

TODAY!

How to sign up for Electronic Fund Transfer
Easy four step process

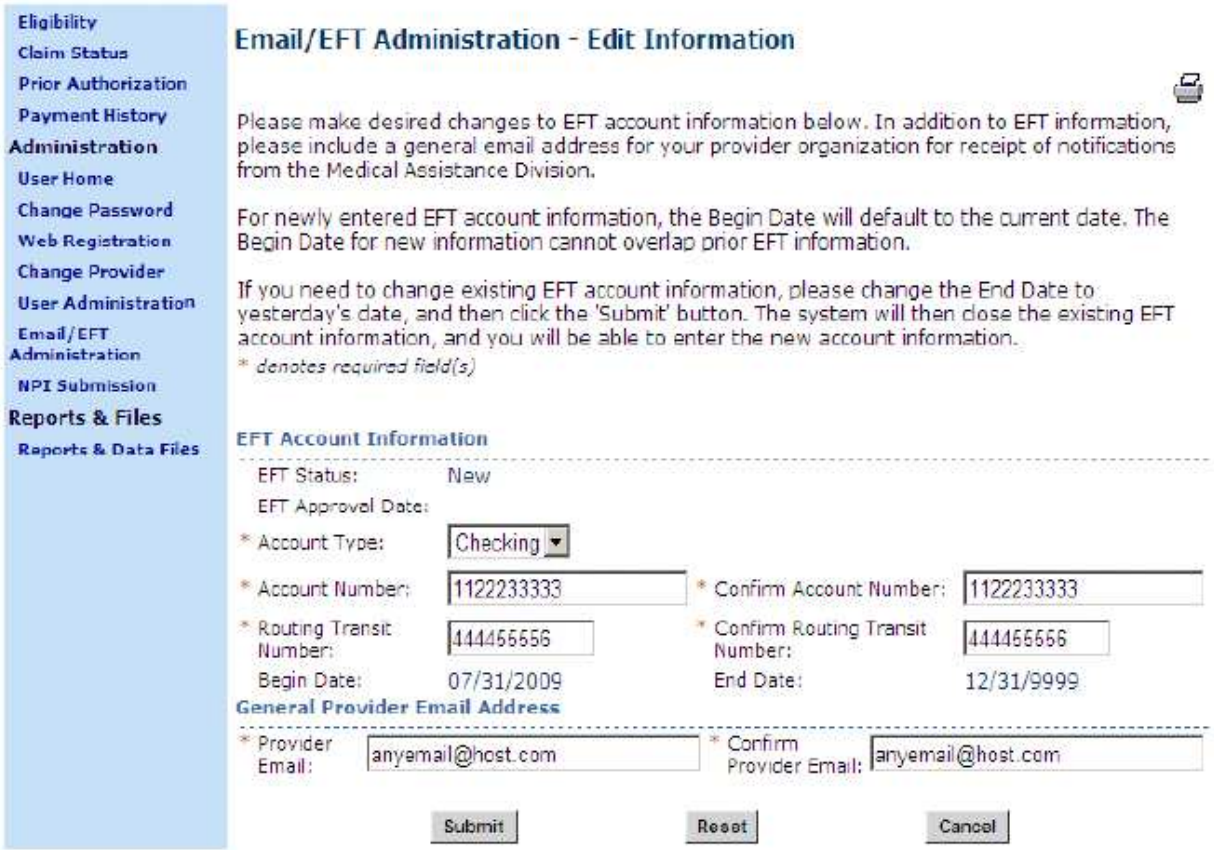
Step One:
Log in to the New Mexico Medicaid Portal as the Master Administrator. In the Links on the left hand side, click on Email/EFT Administration.

Step Two:
Enter your EIN or SSN in the marked box.

ACS
A xerox Company

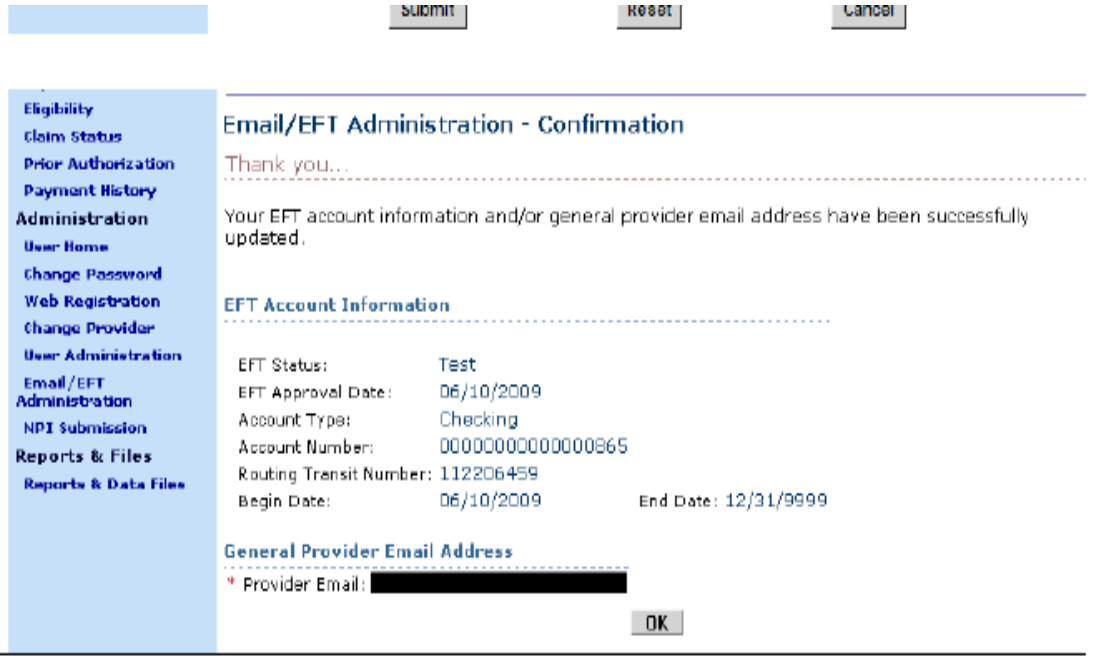
IMPORTANT UPDATE!
Electronic Funds Transfers (EFT)

Step Three:
You will need to fill in your account type, account number and bank routing transit number. You will also need to provide your Email address. Then select submit.



IMPORTANT UPDATE!
Electronic Funds Transfers (EFT)

Step four:
Then you will receive a confirmation.



ACS
A xerox Company

REMINDER!
Remittance Advice Update

Registered Web Portal users are no longer mailed an RA. The current RA and newsletter are available on the web portal, The current RA and newsletter are available on the web portal every Monday, along with last 8 RA's. Please download your RA for future reference

Purpose of workshop

Provide information on filling out the CMS-1500 paper claims for:

- Primary Medicaid
- Medicaid secondary to a Third Party Liability (TPL)
- HMO/PPO copayments
- Medicare replacement plans
- Medicare Crossovers
- Medicaid Tertiary

Eligibility Check List

Date of Service - Make sure client is eligible on DOS

Is the Client Fee for Service, SALUD!, or CoLTS?

Limited Benefits - Check Category of Eligibility

TPL, Medicare, Medicare Replacement Plans - There may be a payer primary to Medicaid

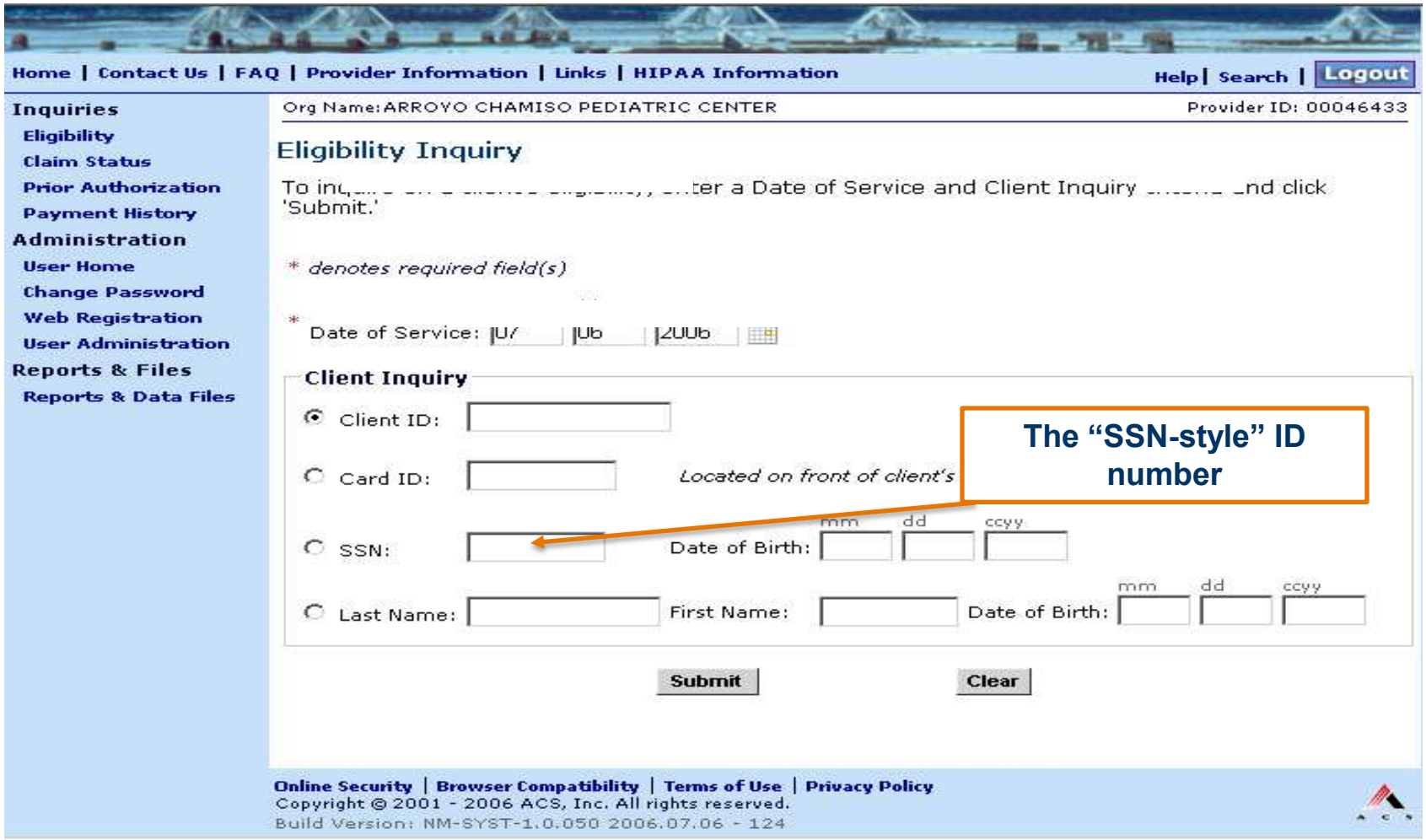
The client may be required to pay a co-pay

Ways to Check Eligibility

On-Line Eligibility Inquiry–Web Portal
https://nmmedicaid.acs-inc.com/

Automatic Voice Response System (AVRS) (505) 246-2219 or (800) 820-6901

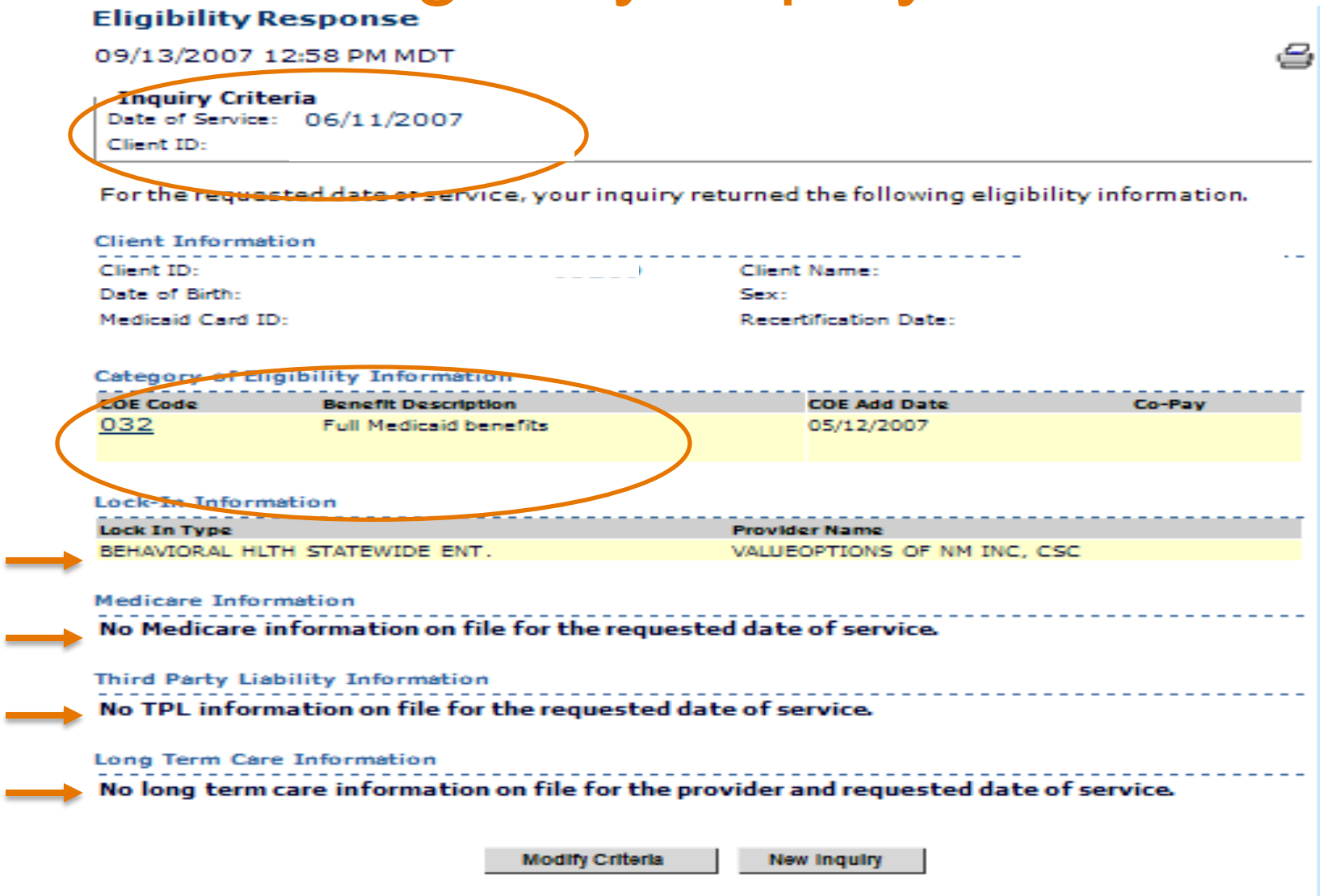
Online Eligibility Inquiry



ACS

A xerox Company

Online Eligibility Inquiry



Eligibility Response

09/13/2007 12:58 PM MDT

Inquiry Criteria
Date of Service: 06/11/2007
Client ID:

For the requested date of service, your inquiry returned the following eligibility information.

Client Information

Client ID:
Client Name:
Date of Birth:
Sex:
Medicaid Card ID:
Recertification Date:

Category of Eligibility Information

COE Code	Benefit Description	COE Add Date	Co-Pay
032	Full Medicaid benefits	05/12/2007	

Lock-In Information

Lock In Type	Provider Name
BEHAVIORAL HLTH STATEWIDE ENT.	VALUEOPTIONS OF NM INC, CSC

Medicare Information

No Medicare information on file for the requested date of service.

Third Party Liability Information

No TPL information on file for the requested date of service.

Long Term Care Information

No long term care information on file for the provider and requested date of service.

Modify Criteria | New Inquiry

ACS
A xerox Company

Claim Form Requirements

All claims that do not require an attachment for payment must be submitted electronically.

Professional claims are submitted on the 837P electronically and the CMS-1500 on paper.

MAD requires that all paper CMS-1500 claim forms be on the original red claim forms.

Photocopies of claim forms are returned to your billing office.

Electronic Claim Submission

All Fee For Service claims within 90 days from the initial date service that do not require an attachment for payment must be submitted electronically.

ACS
A xerox Company

Three Ways to Submit Claims Electronically

Payerpath - Free HIPAA Compliant web-based claims entry system.

TIE (Transaction Interface Exchange) - the State of NM's HIPAA translator. If you have software that will generate a HIPAA compliant file you can directly submit the file to NM Medicaid via TIE. TIE is another free service.

Through a Clearinghouse

Three Ways to Submit Claims Electronically

The URL to the registration form for PayerPath submissions and the Trading Partner Agreement to submit to TIE is:

http://www.hsd.state.nm.us/mad/hipaa.html

CMS-1500 Claim Submission

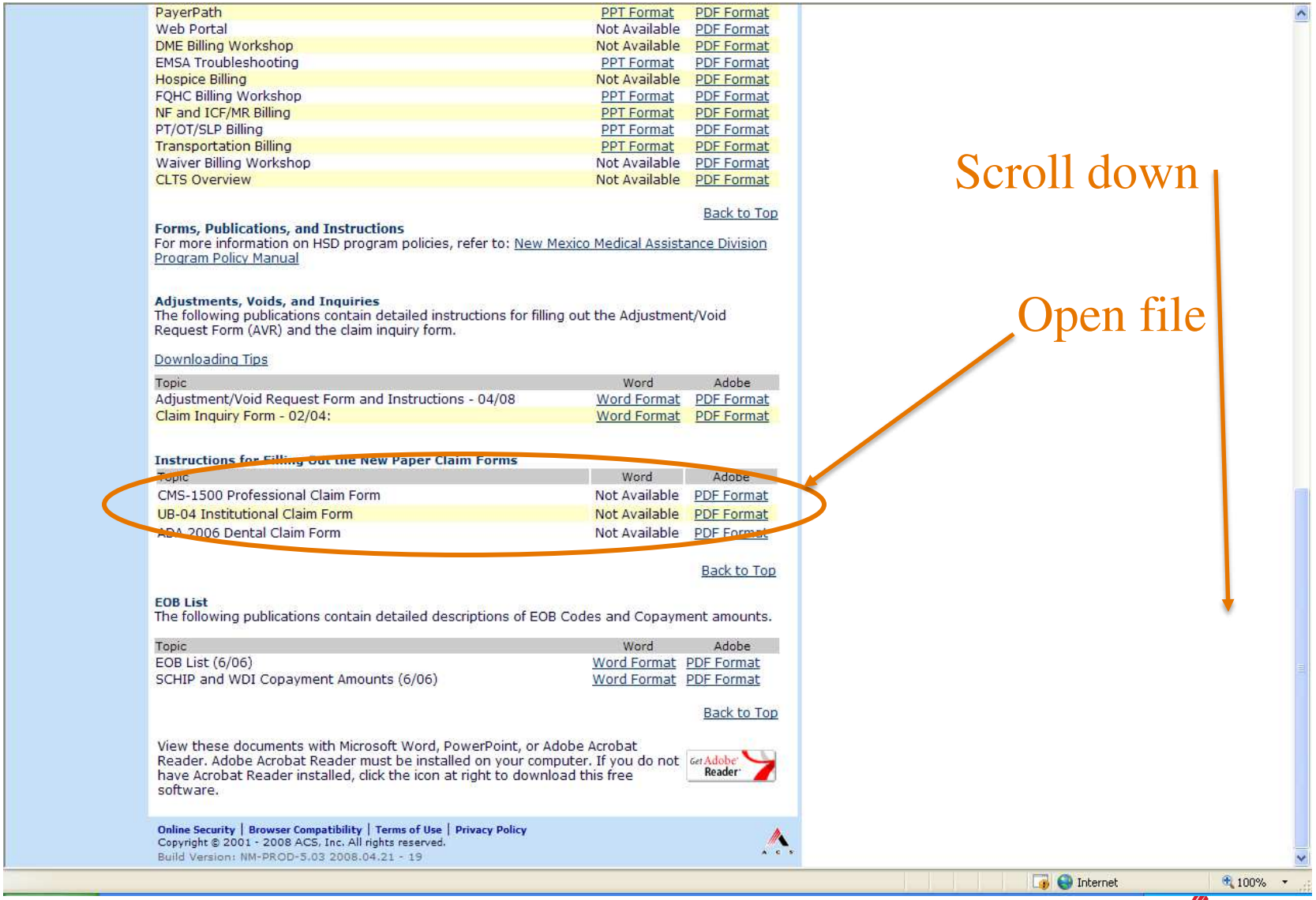
The following claim is how a paper CMS-1500 claim form is generally filled out.

You must use procedure codes, etc. that are specific to your claims.

Where to get a copy of claim form instructions

ACS
A xerox Company

Where to get a copy of claim form instructions



ACS

A xerox Company

Medicaid Primary Claim Forms

ACS

A xerox Company

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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)
111223333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient, Petunia

3. PATIENT'S BIRTH DATE MM DD YY SEX
11 11 90 M ☐ F **X**

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 ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)
( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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)

a. INSURED'S DATE OF BIRTH SEX

b. O

c. E

☐ YES ☐ NO

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.

If a referring provider is required in order to be paid or if you simply wish to enter this information on the claim, enter the referring provider's name in box 17 and the referring provider's NPI in box 17b.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: 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 MM DD YY FROM MM DD YY TO

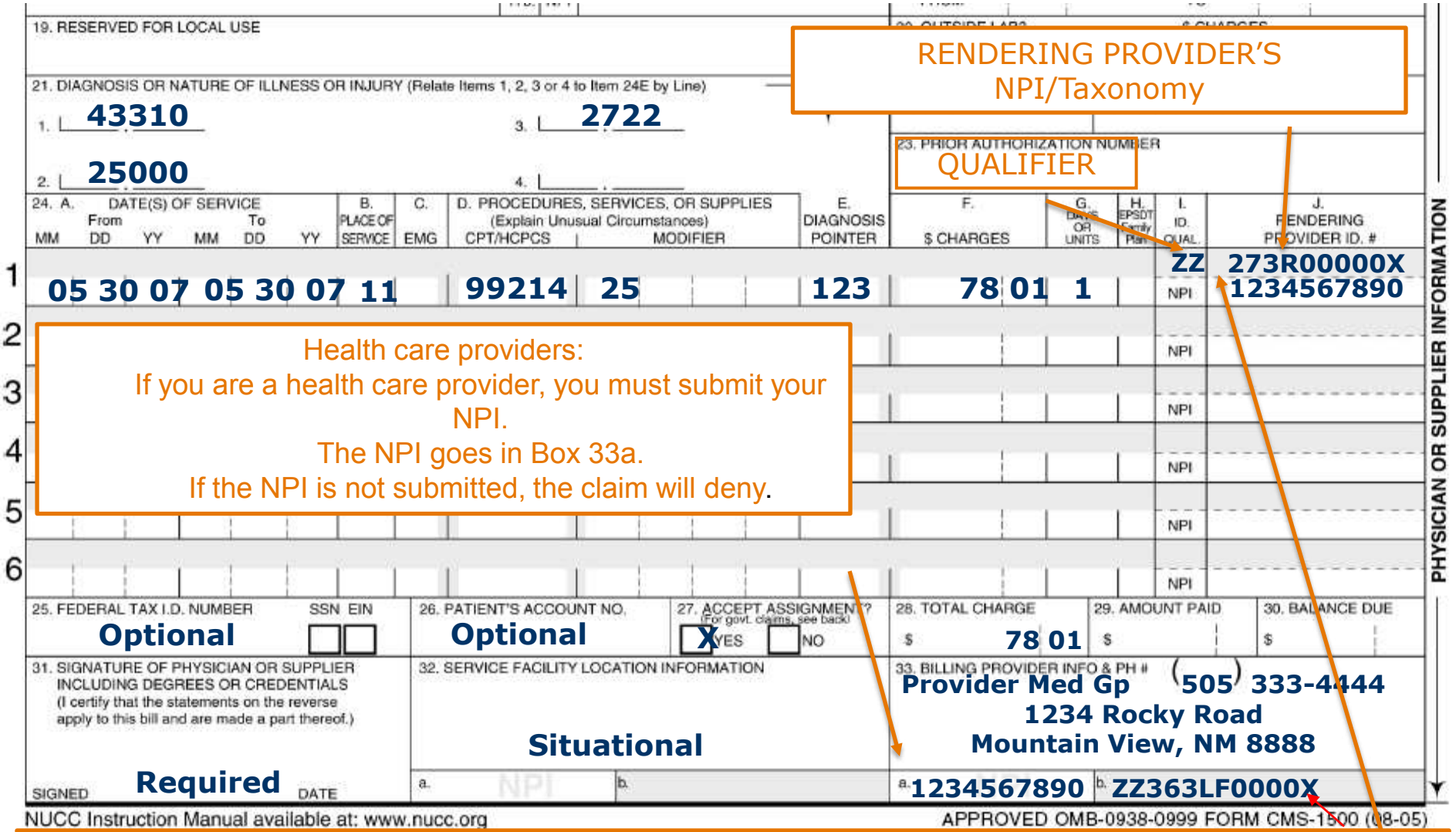
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
Doe, John

17a.

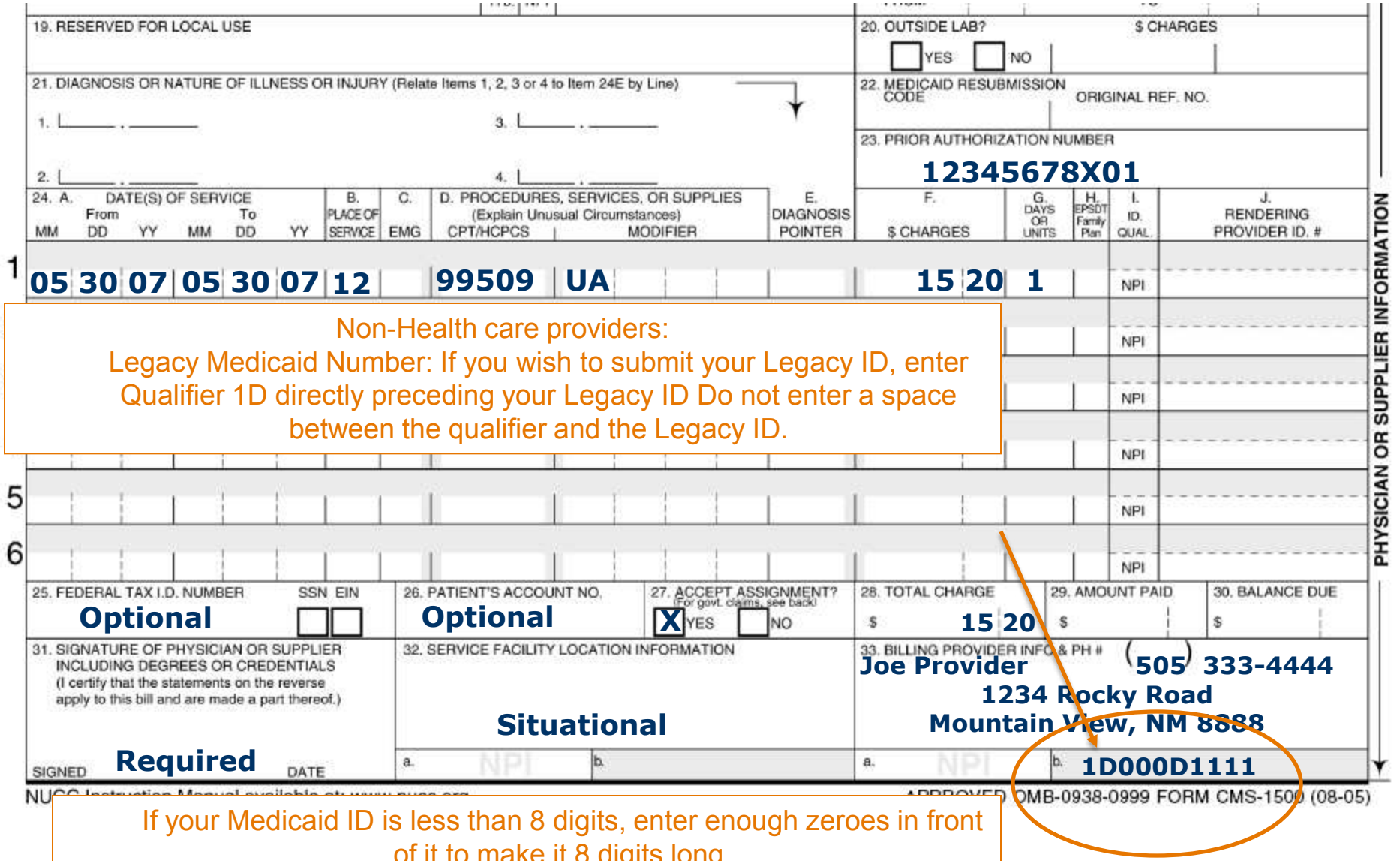
17b. NPI 1223334444

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

ACS
A xerox Company



ACS
A xerox Company



Non-Health care providers:
Legacy Medicaid Number: If you wish to submit your Legacy ID, enter Qualifier 1D directly preceding your Legacy ID Do not enter a space between the qualifier and the Legacy ID.

If your Medicaid ID is less than 8 digits, enter enough zeroes in front of it to make it 8 digits long.

ACS
A xerox Company

Timely Filing Denials

Re-filing Claims and Submitting Adjustments

CMS 1500 form: Put the TCN in block 22 on the paper form. Leave the "Code" blank, and put the TCN in the "Original Reference No." field.

Medicaid Third Party Liability (TPL) Claim Forms

ACS
A xerox Company

Third Party Liability (TPL) Tips

TPL is commercial insurance

TPL must be billed primary to Medicaid

Medicaid does not consider Medicare TPL

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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)
111223333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient, Petunia

3. PATIENT'S BIRTH DATE MM DD YY: **11 11 90** SEX M ☐ F **X**

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)
Patient, Petunia

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
010203

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
09 22 90 M ☐ F **X**

b. AUTO ACCIDENT? PLACE (State)
☐ YES ☐ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
ABC, Inc.

c. OTHER ACCIDENT?
☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
UnitedHealthcare Community Plan

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
X 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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accide PREGNANCY(L

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTH

ON DATES RELATED TO CURRENT SERVICES DD YY TO MM DD YY

PATIENT AND INSURED INFORMATION

When filling out a Medicaid claim where TPL is primary payer, be sure to fill in all required primary and secondary payer information.

ACS
A xerox Company

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. 65663
2. V283
3.
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 05 30 07	05 30 07	11		76811	TC	12	400 00	1		ZZ NPI	273R00000X 1234567890
2 05 30 07	05 30 07	11		76820	TC	12	170 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6					X					NPI	

Attach a copy of the EOB along with the explanation of denials page

Always enter the amount the insurance has paid in Box 29 on the CMS-1500.

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
Optional ☐ ☐	Optional	☐ YES ☐ NO	$ 570 00	$ 120 00	$ 450 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Required SIGNED DATE	Situational a. NPI b.	Provider Med Gp 505 333-4444 1234 Rocky Road Mountain View, NM 8888 a. 1234567890 NPI b. ZZ363LF0000X

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

ACS
A xerox Company

Medicaid HMO/PPO Copayment Claim Forms

ACS

A xerox Company

HMO Co-Pay Tips

Write “HMO Co-pay Due” on the claim. Attach the EOB.

In the “amount paid” field (Box 29), enter the difference between the billed amount and the co-payment.

Enter the co-payment amount in the “est. amount due” field (Box 30).

1500 HMO CO-PAY DUE

HEALTH INSURANCE CLAIM FORM

Write "HMO Co-pay Due" in the upper left hand side of the claim form next to the "1500" and attach the EOB.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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)
111223333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient, Petunia

3. PATIENT'S BIRTH DATE MM DD YY **11 11 1990** SEX M ☐ F **X**

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)
Patient, Petunia

a. OTHER INSURED'S POLICY OR GROUP NUMBER
010203

b. OTHER INSURED'S DATE OF BIRTH MM DD YY
09 22 90 SEX M ☐ F **X**

c. EMPLOYER'S NAME OR SCHOOL NAME
ABC, Inc.

d. INSURANCE PLAN NAME OR PROGRAM NAME
UnitedHealthcare Community Plan

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐

c. OTHER ACCIDENT? YES ☐ NO ☐

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
X 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 _____

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

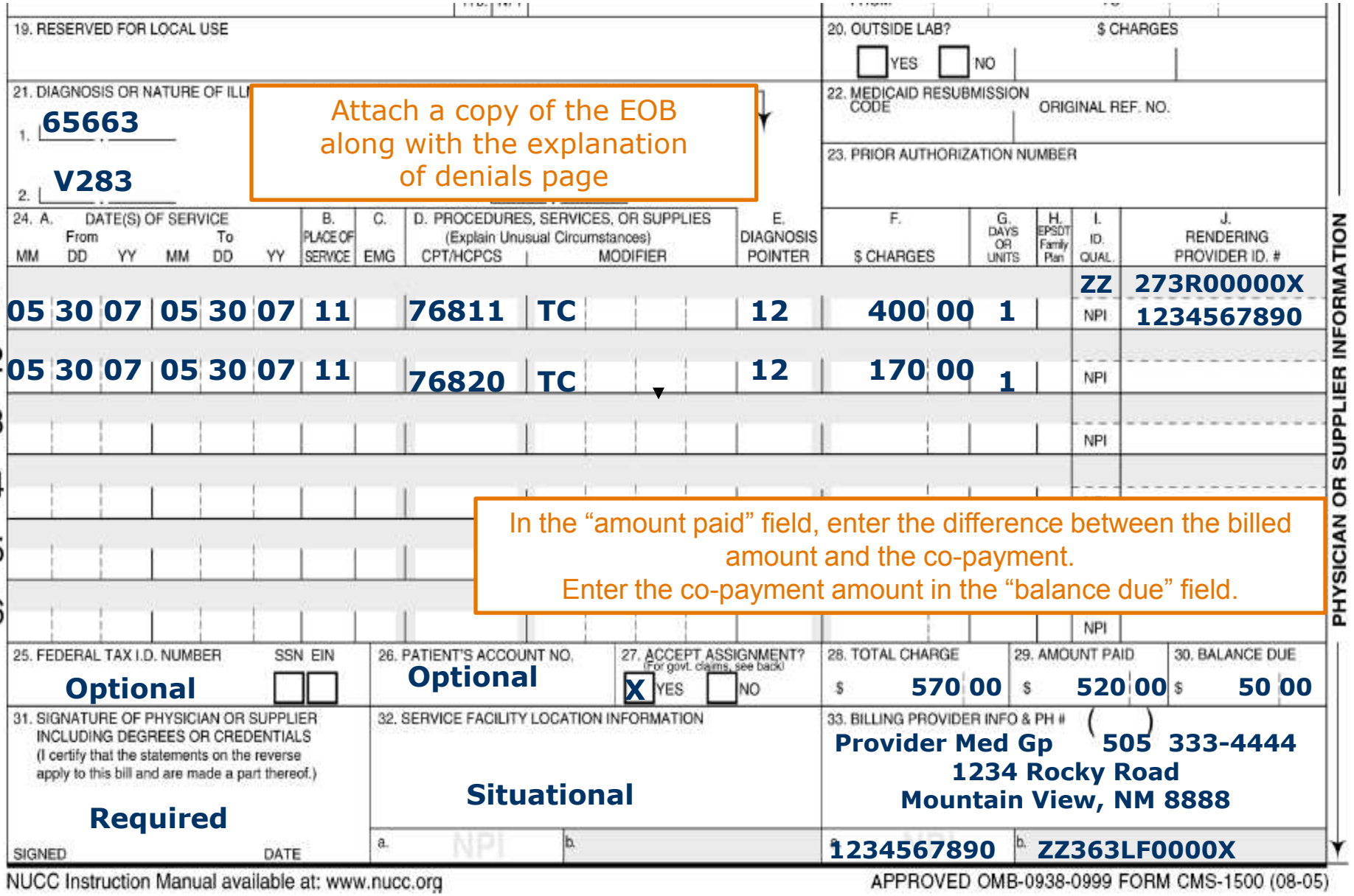
17a.

17b. NPI

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

PATIENT AND INSURED INFORMATION

ACS
A xerox Company



19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILL
1. 65663
2. V283

Attach a copy of the EOB along with the explanation of denials page

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	05 30 07		05 30 07			11		76811	TC	12	400 00	1		ZZ	273R00000X
														NPI	1234567890
2	05 30 07		05 30 07			11		76820	TC	12	170 00	1		NPI	
3														NPI	
4															
5															
6														NPI	

In the “amount paid” field, enter the difference between the billed amount and the co-payment.
Enter the co-payment amount in the “balance due” field.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
Optional

26. PATIENT'S ACCOUNT NO.
Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 570 00

29. AMOUNT PAID $ 520 00

30. BALANCE DUE $ 50 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Required
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Situational
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Provider Med Gp 505 333-4444
1234 Rocky Road
Mountain View, NM 8888
a. 1234567890 b. ZZ363LF0000X

NUCC Instruction Manual available at: www.nucc.org

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

ACS
A xerox Company

Medicare Replacement Plan Claim Forms

ACS

A xerox Company

Medicare Replacement Plan (MRP) Claim Tips

Write “Medicare Replacement Plan Only” on the claim. Attach the EOB.

In the “amount paid” field (BOX 29), enter the difference between the billed amount and the co-payment.

Enter the co-payment amount in the “est. amount due” field (Box 30).

ACS
A xerox Company

1500 **MEDICARE REPLACEMENT PLAN**

Write "Medicare Replacement Plan" in the upper left hand side of the claim form next to the "1500". Attach the EOB.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

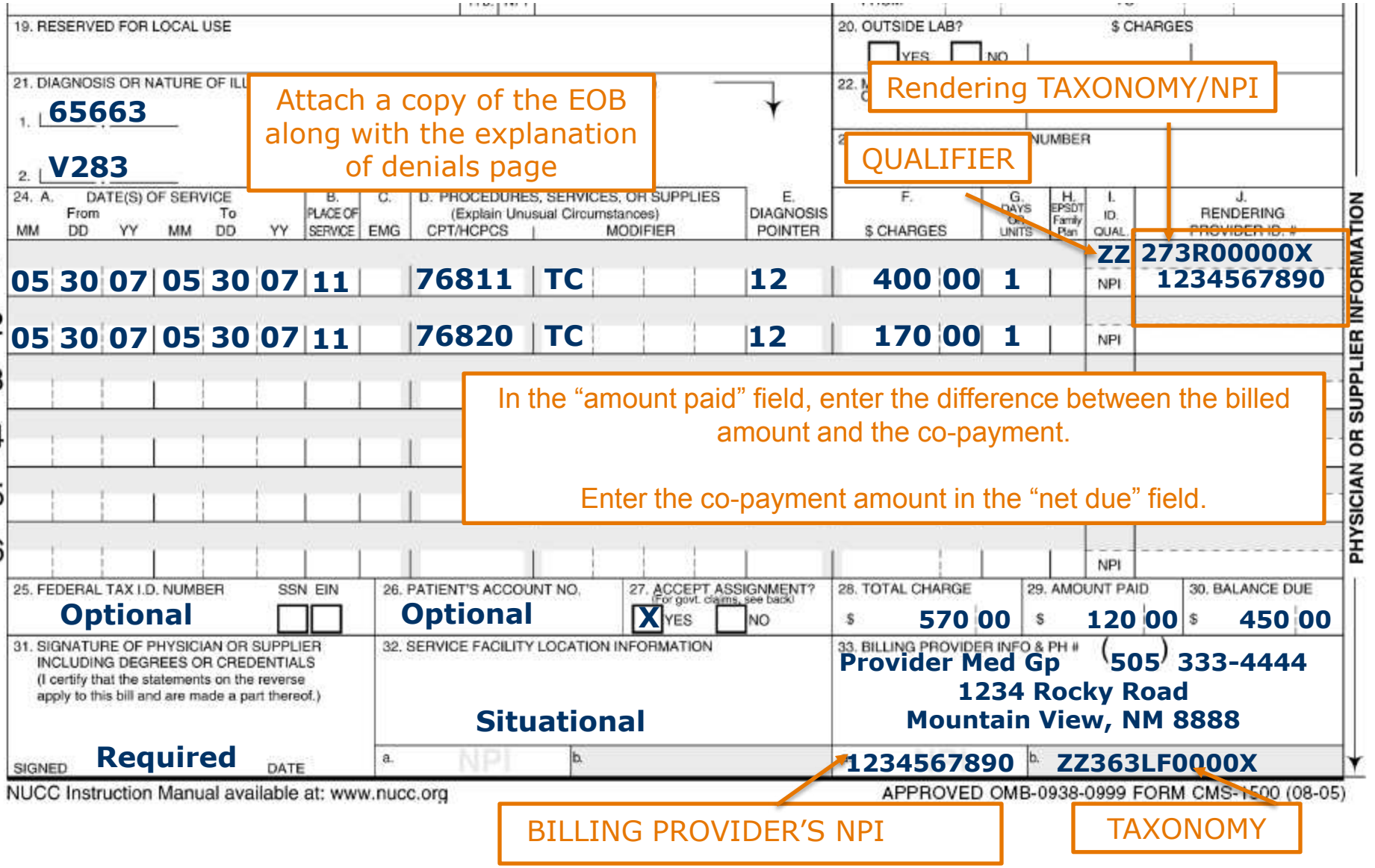
CARRIER

PATIENT AND INSURED INFORMATION

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) **111223333**	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Patient, Petunia**	3. PATIENT'S BIRTH DATE MM DD YY **11 11 1990** SEX M ☐ F **X**	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 ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	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 _____
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 MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

ACS

A xerox Company



(TAXONOMY IS NOT REQUIRED FOR RENDERING PROVIDER)

ACS
A xerox Company

Medicare Primary Claim Forms (Crossovers)

ACS
A xerox Company

Medicare Primary Claims (Crossovers)

When billing for clients covered by Medicare for which Medicare has paid something on the claim and the claim DID NOT automatically crossover from Medicare to ACS, submit those claims via paper to ACS with the Medicare EOMB attached.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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)
111223333

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient, Petunia

3. PATIENT'S BIRTH DATE MM DD YY **11 11 1990** SEX M ☐ F **X**

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

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

CITY

ZIP CODE

TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE

TELEPHONE (Include Area Code) ( )

NM Medicaid does not consider Medicare to be TPL, so be certain that you do not fill in any of the TPL information blocks.

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 _____

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

PATIENT AND INSURED INFORMATION

ACS
A xerox Company

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. 7213 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	05 30 07		05 30 07			24		64483	RT	1	1683 00	1		NPI	
2	05 30 07		05 30 07			24		64484	RT	1	906 00	1		NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Attach a copy of the EOMB along with the explanation of denials page

Don't fill out boxes 29 and 30. We'll key this info directly from the EOMB.

25. FEDERAL TAX I.D. NUMBER SSN EIN
Optional ☐ ☐

26. PATIENT'S ACCOUNT NO.
Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
☒ YES ☐ NO

28. TOTAL CHARGE
$ **2589 00**

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.)

Required

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Situational

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Provider Med Gp 505 333-4444
1234 Rocky Road
Mountain View, NM 8888

a. **1234567890** b. **ZZ273R00000X**

NUCC Instruction Manual available at: www.nucc.org

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

ACS
A xerox Company

Medicaid Tertiary Claim Forms

ACS

A xerox Company

Medicaid Tertiary Claims

Medicaid tertiary claims are submitted in the following order:

- Medicare primary
- TPL secondary
- Medicaid tertiary

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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): **111223333**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Patient, Petunia**

3. PATIENT'S BIRTH DATE MM DD YY: **11 11 1990** SEX M F **X**

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

5. PATIENT'S ADDRESS (No., Street)

Fill out the TPL information

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): **Patient, Petunia**

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **010203**

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: **09 22 90** M F **X**

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME: **ABC, Inc.**

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: **UnitedHealthcare Community Plan**

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? **X** 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 _____

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

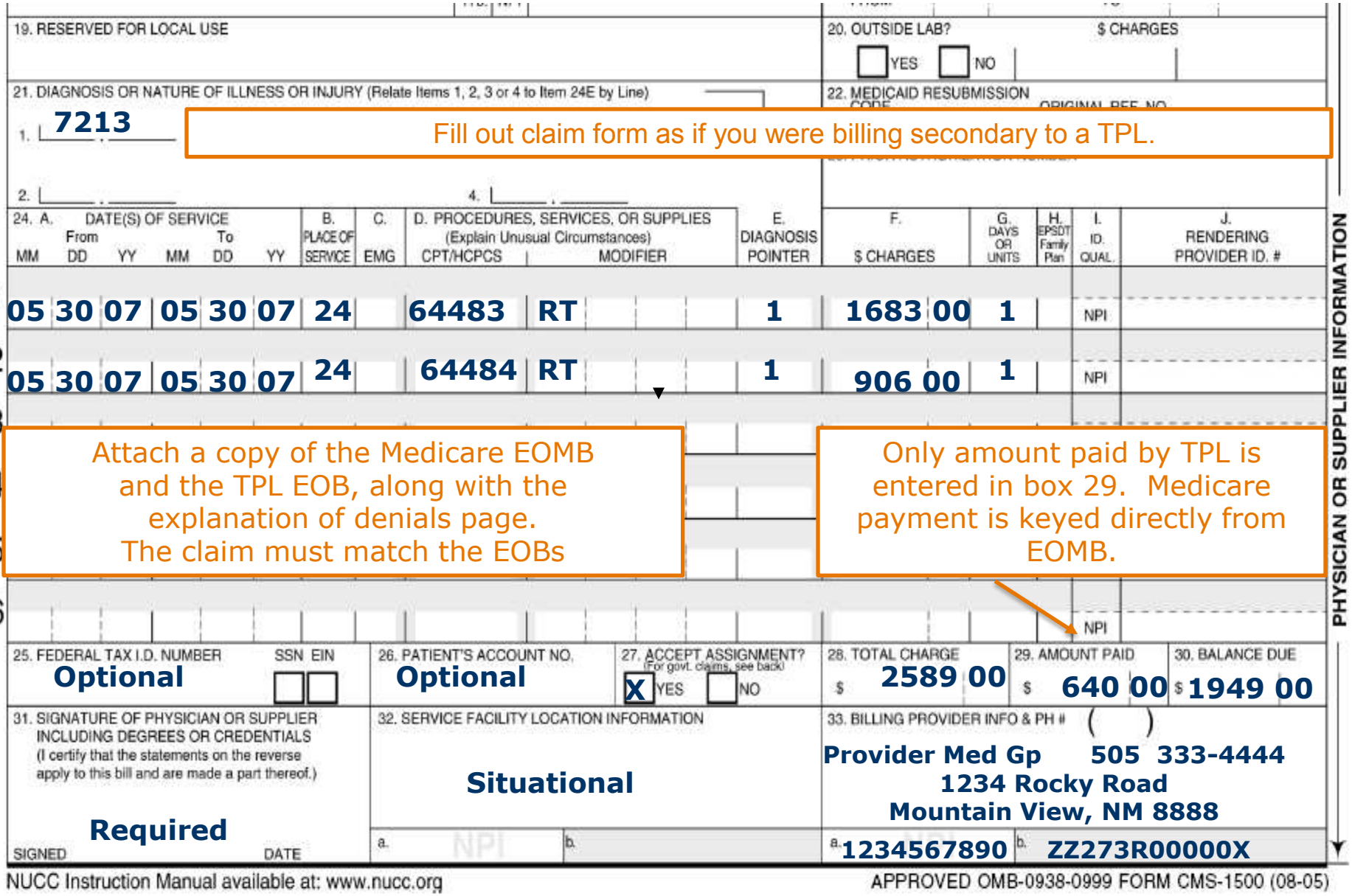
17b. NPI

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

PATIENT AND INSURED INFORMATION

ACS

A xerox Company



ACS
A xerox Company

Did you remember to?

Ensure the line item charges are correct and match the total charge.

If you're a for profit organization, make sure gross receipts tax is included in the line items, if applicable.

Procedure and diagnosis codes are entered correctly

Sign and date the claim.

Did you remember to?

Include your NPI or provider number.

Include all appropriate EOB's for TPL, HMO, Medicare, etc.

Attach proof of timely filing/TCN if needed.

Keep a copy of the correspondence for your records.


ACS
A xerox Company