CMS 1500 claim form requirements

To complete this form, follow the instructions below. **Each field on the form has a corresponding number.** Claims submitted with missing or invalid required fields may be rejected and/or returned for correction and resubmission. **Please note:**
Effective April 1, 2013, all claims must be submitted electronically (except in Clark County, Washington).

Requirements	Field	Description
	1:	Type of Health Insurance Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
Required	**1A:**	**Insured's Identification Number** Enter the three-digit alpha prefix and identification number of the insured *exactly as shown on the member card*.
Required	**2**:	**Patient's Name** Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the member card. *Do not use nicknames.*
Required	**3:**	**Patient's Birth Date and Sex** Enter the eight-digit month, day, century, and year of the patient's birth (MMDDCCYY). Check the appropriate box to identify patient's gender.
Required	**4:**	**Insured's Name** Enter the last name, first name, and middle initial of the insured as shown on the member card. If the patient is the insured, enter the word "same".
Required	**5:**	**Patient's Address** Enter the patient's complete address.
Required	**6:**	**Patient's Relationship to Insured** Check self, spouse, child or other.
	7:	Insured's Address Complete if the patient *is not* the insured.
	8:	Patient Status Check the appropriate box.
Recommended	**9:**	**Other Insured's Name** Enter the name of the insured with other insurance coverage.
Recommended	**9A:**	**Other Insured's Policy or Group Number** Enter the policy and/or group number of the other insurance coverage.
Recommended	**9B:**	**Other Insured's Date of Birth** Enter the information available to you in eight-digit format (MMDDCCYY).
	9C:	Employer's Name or School Name Enter the complete name.
	9D:	Insurance Plan Name or Program Name Enter the name of the insurance plan.

Regence

Requirements	Field	Description
Required	**10:**	**Is Patient's Condition Related to** Check the correct boxes in a., b. and c.
	10D:	Reserved for Local Use Leave blank.
Required	**11:**	**Insured's Policy or FECA Number** Enter the group number of the insured as shown on the member card. **Exception:** If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
Recommended	**11A:**	**Insured's Date of Birth** Use eight-digit date form if submitting.
	11B:	Employer's Name or School Name
	11C:	Insurance Plan Name or Program Name
	11D:	Additional Benefit Plans
Required for Regence MedAdvantage	**12:**	**Patient's or Authorized Person's Signature** Have patient sign if your office requires it or for Regence MedAdvantage patients.
	13:	Insured's or Authorized Person's Signature May be left blank.
Required for accidents or injuries **Recommended for all other**	14:	**Date of Current illness, Injury, Pregnancy** Enter the date of the current illness, injury or pregnancy.
	15:	If Patient has had Same or Similar illness Enter the date the patient first consulted you for this condition.
	16:	Dates Patient Unable to Work in Current Occupation Leave blank.
	17:	Name of Referring Provider or Other Source List the name of the referring, ordering or supervising physician or other health care professional.
See BlueCard requirements in description	17A:	Shaded Area - Other ID # Enter the taxonomy qualifier "ZZ" and the corresponding taxonomy code for the physician or other health care professional listed in field 17. **Effective July 1, 2013, the referring provider taxonomy code is required for independent clinical laboratories, durable medical equipment suppliers and specialty pharmacy claims for BlueCard members.**

Requirements	Field	Description
See BlueCard requirements in description	17B:	NPI # Enter the assigned NPI of the physician or other health care professional listed in field 17. **The referring provider NPI number required for independent clinical laboratories, durable medical equipment suppliers and specialty pharmacy claims for BlueCard members.**
Recommended	**18:**	**Hospitalization Dates Related to Current Services**
	19:	Reserved for Local Use Leave blank.
	20:	Outside Lab If your patient had lab work done, check the correct box *even if you are not billing for the lab work*. Do not list charges in this field.
Required	**21:**	**Diagnosis or Nature of illness or Injury** Identify the patient's condition(s) by entering up to four ICD-9-CM codes in order of relevance. **Codes must be carried out to the highest possible (4th or 5th) digit. Non-specific diagnoses, such as 780, may result in denials.**
	22:	Medicaid Resubmission Leave blank.
Required for Regence MedAdvantage, if applicable	**23:**	**Prior Authorization Number** Enter Clinical Laboratory Improvement Amendments (CLIA) number.
Recommended	**24A – 24G:**	**Shaded Area – National Drug Code (NDC)** In the shaded area above "Date(s) of Service", enter the two digit Product ID Qualifier "N4" identifying the type of number being provided. Enter the 11-digit NDC number immediately after the Product ID Qualifier. **Valid Unit of Measurement Qualifiers are:** F2 – International unit GR – Gram ML – Milliliter UN – Unit The HCPCS code should be entered in Field 24D "Procedures, Services, or Supplies", the charges in Field 24F and the units in Field 24G.
Required	**24A:**	**Date(s) of Service** Enter the date(s) of service. If only one service is provided, the date can be entered as a "from date" or a "to date".

Requirements	Field	Description
Required	**24B:**	**Place of Services** Indicate where services were provided by entering the appropriate two-digit place of service code. Valid codes are as follows: 11 Office 12 Home 17 Walk-in Retail Health Clinic 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance (land) 42 Ambulance (air or water) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Facility 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility
	24C:	Emergency Indicator (EMG Leave blank.
Required	**24D:**	**Procedures, Services, or Supplies: CPT/HCPCS, Modifier** Enter a valid procedure code best describing each service or supply. Explain unusual services or situations with procedure code modifiers. If a CPT and a HCPCS code describe the same service, use the CPT code. **Claims with an invalid or missing procedure code may be denied or returned for correction and resubmission**.
Required	**24E:**	**Diagnosis Pointer** Enter one diagnosis code reference number per claim line (i.e., up to four ICD-9-CM codes) as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis.
Required	**24F**:	**Charges** Enter your charge for each listed service.
Required	**24G:**	**Days or Units** Enter the number of services billed on the line. For anesthesia services, report time and modifier units on separate lines.

Requirements	Field	Description
	24H:	EPSDT Family Plan Leave blank.
Recommended Taxonomy code is required for Regence MedAdvantage **Taxonomy code will be required for all claims effective July 1, 2013**	**24I:**	**Shaded Area - ID Qualifier** Enter the taxonomy qualifier below: ZZ – Provider Taxonomy
Required NPI and Taxonomy code is required for Regence MedAdvantage **NPI is required Taxonomy code will be required for all claims effective July 1, 2013**	**24J:**	**Rendering Provider ID # (split field)** The individual provider performing/rendering the service. **Unlabeled Shaded Field** – Enter the taxonomy code that corresponds with the service being performed by the rendering provider. **NPI Field** - The rendering provider's Type 1 individual NPI number is required. Please submit only one provider number per claim.
Required	**25:**	**Federal Tax ID Number** Enter the provider's tax identification number as given by the Internal Revenue Service.
Recommended	**26:**	**Patient's Account Number** If you use patient account numbers, enter the number for this patient.
Required for Medicare only	**27:**	**Accept Assignment** Please check applicable box.
Required	**28:**	**Total Charge** Enter the total of all charges submitted on this claim.
Recommended	**29:**	**Amount Paid** Enter the exact amount the patient and/or other insurance carrier has paid to you for these services. Entering the words patient paid' without indicating the exact amount may cause claims delays and inaccurate processing.
	30:	**Balance Due** Enter the difference between Field 28 and Field 29.

Requirements	Field	Description
Required	**31:**	**Signature of Physician or Supplier** Sign and date the form. Stamped and preprinted signatures that include the degree are acceptable for all products except Regence MedAdvantage. Claims for this product must be signed or have a preprinted signature including degree.
Required if applicable	**32:**	**Service Facility Location Information** Enter name and address of the location where the services were rendered.
Required if applicable	**32A:**	**NPI #** Enter the service facility NPI number (Type 2) of the service facility location, if known.
Recommended **Taxonomy code required if applicable for Regence MedAdvantage and effective July 1, 2013 for all lines of business**	**32B:**	**Other ID** Enter the two-digit provider taxonomy qualifier "ZZ" followed by the taxonomy code. Do not enter a space, hyphen or other separator between the qualifier and number.
Required	**33:**	**Billing Provider Information and Phone #** Enter the billing provider's name, address, zip code, and telephone number.
Required (Required for paper submitted claims beginning January 1, 2012)	**33A**:	**NPI #** Enter the NPI number (Type 1 or 2) of the billing provider.
Recommended **Taxonomy code required if applicable for Regence MedAdvantage and effective July 1, 2013 for all lines of business**	**33B:**	**Other ID** Enter the two-digit provider taxonomy qualifier "ZZ" followed by the taxonomy code. Do not enter a space, hyphen or other separator between the qualifier and number.

Sample *CMS-1500* (08-05) claim form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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)

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

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

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. #
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									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.

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association