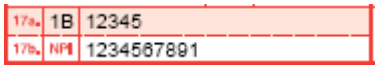
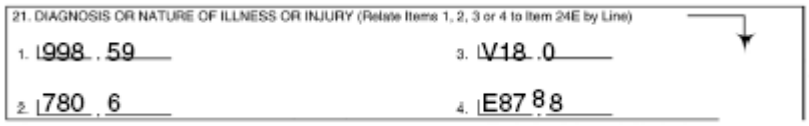
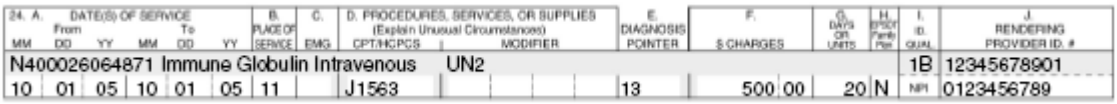
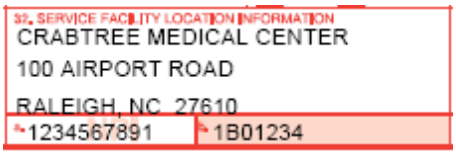
CMS – 1500 (08/05) Claim Filing Instructions

Field #	Description
1.	Leave blank
1a.	Insured's ID - Enter the Member identification number exactly as it appears on the patient's ID card. The member's ID number is the subscriber number and the two-digit suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters. *(Suffixes apply to New Blue products only)*
2.	The patient's name should be entered as last name, first name, & middle initial.
3.	Enter the patient's birth date and sex. The date of birth should be eight positions in the MM/DD/YYYY format. Use one character (X) to indicate the sex of the patient.
4.	Enter the name of the insured. If the patient and insured are the same, then the word "same" may be used. This name should correspond with the ID # in field 1a.
5.	Enter the patient's address and telephone number.
6.	Use one character (X) to indicate the patient's relationship to the insured.
7.	Enter insured's address and telephone number. If patient's and insured's address are the same then the word "same" may be used.
8.	Enter the patient's marital and employment status by marking an (X) in one box on each line.
9.	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient. If the same as Item 4, enter "same" *(complete this block only when the patient has other insurance coverage)*. Indicate "none" if no other insurance applies.
9a.	Enter the policy and/or group number of the other insured's policy.
9b.	Enter the other insured's date of birth (MM/DD/YYYY) and sex.
9c.	Enter the other insured's employer's name or school name.
9d.	Enter the other insured's insurance company name.
10a - c	Use one character (X) to mark "yes" or "no" to indicate whether employment, auto accident, or other accident involvement applies to services in Item 24 *(diagnosis)*.
10d.	Leave Blank
11.	Enter Member's policy or group number.
11a.	Enter Member's date of birth (MM/DD/YYYY) and sex.
11b.	Enter Member's employer's name or school name.
11c.	Enter Member's insurance plan name.
11d.	Check "yes" or "no" to indicate if there is, or not, another health benefit plan. If "yes", complete Items 9 through 9d.
12.	Have the patient or authorized person sign or indicate "SIGNATURE ON FILE" in lieu of an actual signature if you have the original signature of the patient or other authorized person on file authorizing the release of any medical or other information necessary to process this claim.
13.	Have the subscriber or authorized person sign or indicate "SIGNATURE ON FILE" in lieu of an actual signature if you have the original signature of the Member or other authorized person on file authorizing assignment of payment to you.
14.	Enter the date of injury or medical Emergency. For conditions of pregnancy enter the LMP. If other conditions of illness, enter the date of onset of first symptoms.

Field #	Description
15.	If patient has previously had the same or similar illness, give the date of the previous episode.
16.	Leave blank.
17.	Enter name of referring physician or provider.
17a.	Enter **1B** (Blue Shield ID Qualifier) in the shaded area and to the immediate right of 17a. Enter the BCBSNC ID number of the referring provider in the shaded box to the right of the ID Qualifier. (This field is only required if the NP number is not reported in box 17b). ***Example:*** 
17b.	Enter the NPI number of the referring physician or provider.
18.	If services are provided in the hospital, give hospitalization dates related to the current services.
19.	Leave Blank
20.	Complete this block to indicate billing for clinical diagnosis tests.
21.	Enter the diagnosis/condition of the patient indicated by the ICD-9 code. Enter only the diagnosis code, not the narrative description. Enter up to four codes in priority order *(primary, secondary conditions)*. The primary diagnosis should be reported in diagnosis #1. The secondary in #2. Contributing diagnosis in #3 and #4. When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g. E codes), enter the fourth digit on top of the period. ***Example:*** 
22.	Leave Blank
23.	Enter Certification of Prior Plan Approval # here if services require it.

Field #	Description
24.	The 6 service lines in section 24 have been divided horizontally to accommodate submission of both the NPI number and BCBSNC identifier during the NPI transition, and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Use of the supplemental information fields should be limited to the reporting of NDC codes. If reporting NDC codes, report the NDC qualifier "N4" in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = Gram; ML = Milliliter; F2 = International Unit). ***Example:***  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. # N400026064871 Immune Globulin Intravenous UN2 1B 12345678901 10 01 05 10 01 05 11 J1563 13 500 00 20 N NPI 0123456789
24a.	Enter the month, day, and year *(six digits)* for each procedure, service and/or Supply in the unshaded date fields. Dates must be in the MM/DD/YY format.
24b.	Enter the appropriate place of service codes in the unshaded area.
24c.	Leave Blank
24d.	Enter procedure, service, or supplies using the appropriate CPT or HCPCS code in the unshaded area. Also enter, when appropriate, up to four two-digit modifiers.
24e.	Enter the diagnosis reference number *(pointer)* in the unshaded area. The diagnosis pointer references the line number from field 21 that relates to the reason the service(s) was performed (ex. 1, 2, 3, or 4, or multiple numbers if the service relates to multiple diagnosis from field 21). The field accommodates up to 4 digits with no commas between numbers.
24f.	Enter the total charges for each line item in the unshaded area. Enter up to 6 numeric positions to the left of the vertical line and 2 positions to the right. Dollar signs are not required.
24g.	Enter days/units in the unshaded area. This item is most commonly used for units of supplies, anesthesia units, etc. Anesthesia units should be 1 unit equals a 1-minute increment. Do not include base units of the procedure with the time units. If you are billing services for consecutive dates *("from" and "to" dates)* it is critical that you provide the units accurately in block 24g.
24h.	Leave Blank
24i.	Enter 1B (Blue Shield ID qualifier) in box 24i above the dotted line (not required if submitting NPI number).

Field #	Description
24j.	Enter the assigned BCBSNC provider identification number for the performing Provider in the shaded area. If several Members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service. (This field is only required if the NPI number is not being reported). Enter the NPI number of the performing provider below the dotted line. If several Members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service. ***Example:*** 
25.	Enter Federal Tax Identification Number. ☐ Indicate whether this number is Social Security Number (SSN) or Employer Identification Number (EIN).
26.	Enter the Patient Account Number assigned by physician's/provider's/supplier's accounting system.
27.	Accept Assignment ☐ YES must be indicated in order to receive direct reimbursement. Contracting providers have agreed to "accept assignment".
28.	Enter the total charges for all services listed on the claim form in item 24F. Up to 7 numeric positions can be entered to the left of the vertical lines and 2 positions can be entered to the right. Dollar signs are not required.
29.	Enter the amount paid by the primary insurance carrier. *(REMINDER: Only copayments may be collected at time of service.)*
30.	Enter total amount due - charges minus any payments received.
31.	Signature and date of the physician/provider/supplier. *(Stamped signatures are accepted.)*
32.	Enter the name and address of the facility site where services on the claim were rendered. This field is especially helpful when this address is different from billing address in item 33.
32a.	Enter the NPI number of the service facility.
32b.	Enter the ID qualifier **1B** immediately followed by the BCBSNC assigned five-digit provider identification number for the service facility (This field is not required if submitting the NPI number in field 32a). ***Example:*** 
33.	Enter the name, address, and phone number for the billing provider or group.

Field #	Description
33a.	Enter the NPI number of the billing provider or group.
33b.	Enter the ID qualifier **1B** immediately followed by the BCBSNC assigned five-digit provider identification number for the billing provider or group. (This field is not required if submitting the NPI number in field 33a). ***Example:***