Sample CMS-1500 Claim

A sample claim of the most commonly used fields. Contact your insurance company for further information regarding data entry requirements.

| | PAYER NAME | | |
|--|--|--|------------------------------------|
| [1500] | PAYER ADDRESS PAVER ADDRESS 2 | | |
| HEALTH INSUBANCE CLAIM FORM | CITY ST ZIP | | |
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 00/05 | | | |
| PICA | | | PICA |
| 1. MEDICARE MEDICAID TRICARE CHAMPV | A GROUP FECA OTHER | 1a. INSURED'S I.D. NUMBER | (For Program in Item 1) |
| (Medicare #) (Medicaid #) (Sponsor's SSN) (Member IC | M) HEALTH PLAN BLK LUNG (ID) | 9999999999 | A 1.4 |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENTS BIRTH DATE SEX | 4. INSURED'S NAME (Last Name, First Na | ame, Middle Initial) |
| SAMPLE PATIENT | 02211967 MX - | SAMPLE PATIENT | |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS (No., Street) | |
| 123 MAIN STREET | Set X Spouse Child Other | 123 MAIN STREET | |
| CITY STATE | 8. PATIENT STATUS | CITY | STATE |
| CITY ST | Single Married Other | CITY | ST |
| ZIP CODE TELEPHONE (Include Area Code) | Full-Time Part-Time | ZIP CODE TELEPI | HONE (Include Area Code) |
| 99999 (555) 444 3333 | Employed Student Student | 99999 (5 | 55) 444 3333 |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: | 11. INSURED'S POLICY GROUP OR FEC | A NUMBER |
| | - FUELOWIENES (Consultor Device) | | 052 |
| a. OTHER INSURED & POLICE OF BROUP NUMBER | | MM DD YY | |
| b. OTHER INSURED'S DATE OF BIRTH | b. AUTO ACCIDENT? | U4211967 | <u>"A</u> ' <u>L</u> |
| MM DD YY SEX | PLACE (State) | WEMPLOTER S NAME ON SCHOOL NA | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | 6. OTHER ACCIDENT? | 6. INSURANCE PLAN NAME OR PROGR | AM NAME |
| | | MEDICADE | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEF | IT PLAN? |
| | | YES NO If yes, ret | turn to and complete item 9 a-d. |
| READ BACK OF FORM BEFORE COMPLETING | & SIGNING THIS FORM. | 13. INSURED'S OR AUTHORIZED PERSO | ON'S SIGNATURE I authorize |
| PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the in to process this claim. I also request payment of government benefits either. | elease of any medical or other information necessary to myself or to the party who accepts assignment | payment of medical benefits to the und services described below. | ersigned physician or supplier for |
| below. | | | |
| SIGNED | DATE | SIGNED | |
| 14. DATE OF CURRENT: ILLNESS (First symptom) OR 15. | F PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | 16. DATES PATIENT UNABLE TO WORK | IN CURRENT OCCUPATION |
| 06292009 PREGNANCY(LMP) | SIVE FINST DATE | FROM | то |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a | | 18. HOSPITALIZATION DATES RELATED | TO CURRENT SERVICES |
| 17b | NPI | FROM | то |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? | S CHARGES |
| | | YES X NO | |
| 21. DIVIGNOSIS OR INFORE OF ILLINESS OR INJURY (Helate items 1, 2, | 3 or 4 to fibm 24E by Line) | CODE ORIGIN | AL REF. NO. |
| 1/1300.4 3. | · | 25 PRIOD AUTHORIZATION NUMBER | |
| - | | AND THE REPORT OF THE REPORT O | |
| 24. A. DATE(S) OF SERVICE B. C. D. PROCE | DURES, SERVICES, OR SUPPLIES | E G H | L L |
| From To PLACEOF (Expla | in Unusual Circumstances) DIAGNOSIS | S CHARGES OR Family | D. RENDERING |
| and out in the to the period of the | NOUTER POINTER | g onenacio | Providen IV. # |
| | 6 1 1 | 70001 11 5 | 4P1 |
| 002220031002220031111 13000 | · · · · · · · · | | |
| | 6 1 | 70001 11 | VPI |
| | · · · · · · · | | |
| 07012009 07012009 11 9080 | 6 1 | 70 00 1 | IPI |
| 1 | · · · · · · | | |
| | | N N | VP1 |
| 5 | | | |
| | | | NPI |
| 8 | | | |
| | | | |
| 25. PEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENT'S A | CCOUNT NO. 27. ACCEPT ASSIGNMENT? Por govt. clamp. see back | 28. TOTAL CHANGE 29. AMOUN | O DO C DO C |
| ZZZ 3334444 X 12345 | | | |
| INCLUDING DEGREES OR CREDENTIALS | GILLET LOCATION INFORMATION | SS. BILLING PHOVIDER INFO & PH # | (555) 555 5555 |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | SAMPLE DOCTOR | |
| | | ANYTOWN MT 4444 | 4 |
| SIGNATURE ON FILE | 5 b. | 81224567000b | • |
| | | 1***17.3 45678910* | |

NUCC Instruction Manual available at: www.nucc.org

Printer Adjustment

Menu Location: File > Printer Adjustment

How do I adjust the Form Filler program to my printer?

IMPORTANT: You must use an original, pre-printed CMS-1500 form. Do not use a copied or faxed CMS-1500 form. Also, if you are using an ink-jet or laser printer, you must use the single sheet CMS-1500 forms. Do not use the multi-part continuous feed forms in a laser or inkjet printer.

| Printer Adjustment Print Alignment Steps to align the printing on the claim form. 1. Load your printer with CMS-1500 Forms 2. Click the Print Test Page button to print out a test page 3. Change the two values below to position the 'X' into the Medicare check box 4. Print another test page and repeat this procedure until the X' is positioned in the center of the Medicare check box Up/Down 0 + Value moves up -Value moves down Left/Right 0 + Value moves left Adjustments are in 100ths of an inch so a value of 50 would be 1/2 inch. Print Test Page | Bottom Margin If the text in box 31, 32, or 33 is being cut off, select one of the options below to use when printing. Normal Spacing Carrier Area Location Adjustment Up/Dn Image: the data at the top of the form lines up properly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines up properly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines up properly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines up roberly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines up roberly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines up roberly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines up roberly but slowly starts to move down or up, adjust this setting. Image: the data at the top of the form lines Ima |
|--|---|
|--|---|

Follow the steps below and your forms will print out correctly.

- 1. Click on 'File' on the menu bar and then 'Printer Adjustment'.
- 2. Load your printer with CMS-1500 forms.
- 3. Click the 'Print Test Page' button.
- Following Printer Adjustment instructions, change values until the X is positioned in the center of the Medicare check box at the top of the CMS-1500 form. (Suggestion: Continue using the same form until adjusted)
- 5. When adjustment is correct, click on OK.
- Note: After setting printer values you must click on OK to set values.

Bottom Margin Adjustment

Menu Location: File > Printer Adjustment

When I print the 1500 form, boxes 31, 32 and 33 are being cut off. How do I adjust?

On some printers, the data at the bottom of the form will not print; adjust the font to 'Smaller Font 'or 'Tight Spacing'.

- 1. Click on 'File' on the menu bar and then 'Printer Adjustment'.
- 2. Go to 'Bottom Margins' and using the drop down arrow choose 'Smaller Font' or 'Tight Spacing.'

Carrier Area Location Adjustment

Menu Location: File > Printer Adjustment

The insurance address is not centered in the envelope window. How do I adjust?

If you are using windowed envelopes it is recommended you use 'claim form envelopes'. It may be necessary to adjust the carrier area to print out correctly for the envelope window.

- 1. Click on 'File' on the menu bar and then 'Printer Adjustment'.
- 2. Go to 'Carrier Area Location Adjustment'.

3. Adjust the 'Up/Down' and 'Left/Right' values as needed to line up the address with the envelope window.

Vertical Shift Adjustment

Menu Location: File > Printer Adjustment

The printing at the top is OK but the bottom is not, how do I adjust the printing?

Some printers do not feed the paper at the same speed as others. If the data on the CMS form starts to 'shift' out of position, you can use this setting to adjust it.

- 1. Click on 'File' on the menu bar and then 'Printer Adjustment'.
- 2. Go to 'Vertical Shift Adjustment'.
- 3. Adjust the 'plus and minus' values to shift the printing up or down.

Font Settings

Menu Location: File > Printer Adjustment

The font is too small (or large). How do I adjust the size of the font?

- 1. Click on 'File' on the menu bar and then 'Printer Adjustment'.
- 2. Go to 'Font Setting'.
- 3. Click on the 'Select' button.
- 4. Choose alternate font.

EZClaim Form Filler Quick Start

For National Uniform Claim Committee (NUCC) instructions on completing the 1500 form go to http://www.nucc.org/

Follow steps 1-5 to complete your first CMS 1500 form. Refer to the CMS 1500 form for 'Box' numbers.

Billing Library (Box 33) – Step 1

Menu Location: Tools > Billing Library

Required: Box 33 – Billing Name

| Billing Library | |
|---|--|
| Select from the list to Edit COMMUNITY COUNSELING SAMPLE DOCTOR | Box 33 - Billing Info Billing Name: SAMPLE DOCTOR Address: 333 MAIN STREET City, State, Zip: ANYTOWN MI 44444 Phone: (555) 555-5555 NPI: 1234567890 Box 25 - Tax ID Tax ID: 2223334444 This tax ID is a: • SSN C EIN |
| Delete | New Close Save |

- 1. Enter 'Billing Name', Address and NPI number.
- 2. Enter the Tax ID or SS# associated with the 'Billing Name' NPI.
- 3. 'Save' data.
- 4. Enter multiple 'Billing Info' data if provider information entered into Box 33 is different depending on the insurance company
- 5. This information will be selected using a 'dropdown' on the Physician/Diag Info tab when entering the claim data.

Deleting a Billing Library Entry

Note: Deleting a 'Billing Library' entry will delete the information from all claims using that Billing Provider Information. The following message will be displayed.

| <u> </u> | There are 1 patients usin will need to assign a new Do you still want to dele | g this billing entry v billing entry to t te? | y. If you delete th hose patients. | is entry, you |
|----------|---|---|---------------------------------------|---------------|
| | 1 | Ver | NL | Curved |

Payer Library - Step 2

Menu Location: Tools > Payer Library

Situational : <u>Why would I use the Payer Library?</u>

- 1. To keep a database of the Insurance Carrier used by the provider for submitting claims.
- 2. To enter Insurance Carrier address information in the Carrier Area. (Top right corner of CMS-1500 form.)

To open the Payer Library, click on the Tools menu and select 'Payer Library'.

| Payer Library | | > | |
|---------------------|-----------------------------------|-------|--------|
| Payer Name: | MEDICARE | | Add |
| Street Address 1: | 555 FRONT STREET | | Close |
| Street Address 2: | |] – | Edit |
| City/State/Zip: | ANY CITY NY 55544 | - | Dalata |
| Telephone: | | | Delete |
| Select a payer then | click the Edit or Delete buttons: | | |
| Name | Address | State | |
| MEDICARE | 555 FRONT STREET | NY | |
| PAYER NAME | PAYER ADDRESS | ST | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| 1 | | | |

Add Payer Information to Library

- 1. Enter name and address data
- 2. Click on the 'Add' button
- 3. 'Telephone' number will not print on the 1500 form.

Payer information is now listed in the box below.

Edit Payer Information in Library

To edit information in the Payer Library follow directions below.

- 1. Select by highlighting Payer to 'Edit' from the list in the Payer box.
- 2. Click the 'Edit' button or double click the payer.
- 3. Edit information
- 4. Click the 'Add' button

Payer information is now listed in the box below.

Delete Payer Information from Library

- 1. Select by highlighting the 'Payer' to be deleted
- 2. Click on the 'Delete' button.

Entering Claim Data

NO NEED TO USE A **"SAVE**" OR **"MEMORIZE**" FUNCTION WHEN ENTERING DATA. <u>ALL</u> DATA IS AUTOMATICALLY SAVED/MEMORIZED WHEN ENTERED INTO APPROPRIATE FIELDS.

Patient/Insured Info tab - Step 3

When Form Filler first starts, the 'Patient/Insured Info' screen is ready to input new patient data. This screen represents the top half of the CMS-1500 form, so enter data just as you would on a CMS-1500 form.

| SAMPLE, PATIENT - DR. JOHN SAMPLE - M iile Edit Patient Claim Tools Support | EDICARE - EZClaim Form Filler Plus - Version t/Help = EZClaimFormFiller.com! | 7 Release 1 📃 🔳 | | |
|--|--|--|--|--|
| New Patient - F2 New Patient Using a Templa | ate - F3 Find Patient - F4 Claim Archives - | F5 Enter New Claim Charges - F6 Exit - F10 | | |
| Patient/Insured Info Physician/Diagnostic Info | New Charges Charges: \$210.00 4/8/2009 | | | |
| Medicare Medicaid Champus Champva | Group FECA Other 〇 〇 〇 | Insured's ID Number 9999999999 | | |
| Patient Last Name First Name MI SAMPLE PATIENT | Patient Date of Birth Sex 2/21/1967 • M C F Copy ->> | Insured's Name (Last, First, MI) SAMPLE PATIENT | | |
| Patient Address 123 MAIN STREET | Patient Relationship to Insured ● Self ⊂ Spouse ⊂ Child ⊂ Other | Insured Street Address (No. Street) 123 MAIN STREET | | |
| , City State CITY ST | Patient Status C Single C Married C Other | City State | | |
| Zip Code Phone Number 999999 (555) 444-3333 | Patient Employment Status C Employed C Full-Time C Part-Time Student Student | Zip Code Phone Number 999999 (555) 444-3333 | | |
| Other Insured's Name | Is Patient's Condition Related To: Employment O Yes I No Place (State) | Insured's Policy Group or FECA Num. | | |
| , Other Insured's Policy or Group Number | Auto Accident O Yes No | | | |
| Other Insured's DOB Sex | Local Use | , Employer's Name Or School Name | | |
| Other Employer's Name or School Name | Patient Sig On File | nsurance Plan Or Program Name | | |
| 0 Other Insurance Plan Name or Program Name | Print Current Date Or Insured Sig On File | MEDICARE Is There Another Health Benefit Plan? | | |
| Patient <u>N</u> otes | - , | 🗌 Print Form & Data | | |

Most commonly used fields.

Box 1 - Select Insurance carrier by clicking in the check box.

Box 1a – Enter Insured ID Number.

Box 2 &5 - Enter Patient Information. (Once Patient Data is entered, you may use the Copy> button to copy data to right side of form.)

Box 3 – Enter Patient's Birth Date.

Box 4 - Enter Insured information.

Box 6 - Check 'Patient Relationship to Insured'.

Box 9 a-d – Other Insured Information if required.

Box 10 – Reserved for Local Use. Optional information determined by your insurance company.

Box 11 – Insured Policy Group or FECA Number if required.

Box 12 - Check 'Patient Signature on File'. Enter Date or check date checkbox.

Box 13 – Check 'Insured Signature on File' if you are requesting payment of this claim to be sent to the Provider.

Enter any additional information if required by the insurance company.

Physician/Diagnostic Info tab - Step 4

This screen represents the bottom half of the CMS-1500 form along with additional data entry features.

Please Note: The following explains the areas on this screen that do not follow the CMS-1500 form exactly:

What are 'Default Values'?

| Enter Dates of Service and Charges on the New Charges Screen. See Help file, Claim Form Default Values. | | | | | | | | | |
|---|------------------------|--|--|--|--|--|--|--|--|
| Diagnosis Or Nature Of Illness Or Injury * Prior Authorization No. | | | | | | | | | |
| 1. 3004 2. 3. | 4. | | | | | | | | |
| Place* EMG_CPT/HCPCS* Modifier* | Diag. Line # Charge Ar | mount Paid Units EPSDT Qual Rend Prov ID | | | | | | | |
| 11 90806 | 1 \$70.00 | \$0.00 1 | | | | | | | |
| | | | | | | | | | |

The Default Values section on the Physician/Diagnostic screen is one of the reasons the Form Filler is so convenient and easy to use.

Often patients have the same codes for each date of service. Enter into this section <u>only those codes that</u> <u>are used</u> for every date of service for this patient. Most commonly used are 'Place of Service' and 'Rendering Provider' data.

When clicking on calendar dates from the 'New Charges Tab', these default entries will be automatically entered.

IMPORTANT NOTE: If using the Default Values section, data must be entered into Default section **BEFORE** entering data into the New Charges screen.

| Edit Patient Claim Tools Supp | ort/Help EZClaimFormFiller.com! | |
|---|--|---|
| lew Patient - F2 New Patient Using a Tem | plate - F3 Find Patient - F4 Claim Archives | s • F5 Enter New Claim Charges • F6 Exit • F1 |
| Patient/Insured Info Physician/Diagnostic In | fo New Charges Charges: \$150.00 4/17/2009 | 1 |
| Date Of Current 6/29/2009 | First Date Of Similiar Illness | Dates Patient Unable To Work |
| Name Of Referring Physician NP | 1 Qualifier and Other ID | Hospitalization Dates Rel. To Current Services |
| Reserved For Local Use | Outside Lab Charges | Medicaid Resub. Code Original Ref. No. |
| Diagnosis Or Nature Of Illness Or Injury * 1. 3004 2. 3. Place* EMG CPT/HCPCS* Mod 11 90806 | 4 | Prior Authorization No. Paid Units EPSDT Qual Rend Prov ID |
| Federal Tax ID Number 2223334444 | Patient Account No Accept Assignme IN 12345 C Yes C No Pe Facility Name/Address/NP/Qual/Other ID | ent Billing Provider Info, click the button to edit O SAMPLE DOCTOR |
| 🗌 🗖 Print 🛙 | Date | ANYTOWN MI 44444 |
| Carrier Area: Assign Payer Clea PAYER NAME PAYER ADDRESS PAYER ADDRESS 2 | | NPI Qualifier and Other ID |

Note: Below are the most commonly used data entry fields, contact your insurance company for additional data requirements.

Box 14 - 'Date of Current' if required by your insurance company. Medicare usually requires this data.

Box 17 - If required by your insurance company, enter 'Referring Provider' name and NPI number.

Box 19 - Reserved for Local Use – Optional data entry determined by your insurance company.

Box 25 - Data will be automatically entered when the 'Billing Provider Info' is selected.

Box 26 - Enter 'Patient Account Number'. You may use a number of your choice or go to Tools>Options>Data Entry Options and check the box for "Automatically enter a Patient Acct. #".

Box 27 - Check the 'Accept Assignment' indicator, 'Yes' or 'No'.

Box 31 - Type Rendering Provider name in Box 31 or check 'Signature on File' and 'Print Date' checkbox.

Box 32 - Facility Information if required by your insurance company.

Box 33 - Billing Provider Info and NPI number. Use the dropdown to select 'Billing Info' previously entered under Tools>Billing Library.

- If required by your insurance company, enter Provider or Group number in the 'Qualifier and Other ID' field. See Qualifiers below.
 - 0B State License Number
 - 1B Blue Shield Provider Number
 - 1C Medicare Provider Number
 - 1D Medicaid Provider Number
 - 1G Provider UPIN Number
 - 1H CHAMPUS Identification Number
 - EI Employer's Identification Number
 - G2 Provider Commercial Number
 - LU Location Number
 - N5 Provider Plan Network ID Number
 - SY Social Security Number
 - X5 State Industrial Accident Provider Number
 - ZZ Provider Taxonomy

Carrier Area for Payer Information

1. To enter the 'Insurance Name and Address' for this patient in the Carrier Area, go to the bottom left corner of the Physician/Diag screen. Click on 'Assign Payer' to open the Payer information previously set up in the Payer Library. See 'Step 2' for setting up the Payer Library.

| Carrier Area: | Assign <u>P</u> ayer | <u>C</u> lear |
|---------------|----------------------|---------------|
| PAYER NAM | E BESS | * |
| PAYER ADD | RESS 2 | |
| CITY ST ZIP | | Ŧ |

2. Highlight Payer and click' OK'. Insurance company name is now listed in the Carrier Area and will print in the top right corner of your CMS 1500 form.

| elect Payer | | | | × |
|-------------|--------------|-------------|----|---|
| Name | Address 1 | Address 2 | ST | |
| MEDICARE | 555 FRONT S | | NY | |
| PAYER NAME | PAYER ADDR | PAYER ADDR | ST | |
| , | Edit Payer L | .ist Cancel | 0 | ĸ |

Charges tab – Step 5

Click on the Charges tab to enter dates of service.

| 🗊 SAMI | PLE, PATIEN | IT - DR. JOH | N SAM | PLE - M | EDICARE | - EZ | Claim | Form | Filler | Plus - | Version | 17 Re | lease 1 | | | | , • 💌 |
|---|--|----------------------|--------------|----------------------------|---------------------|--------------|--------------|-----------------|-----------------|----------|----------------|----------|----------------|--------------|-------------------------|--------------------|---------|
| File Edit Patient Claim Lools Support/Help EZClaimFormFiller.com! | | | | | | | | | | | | | | | | | |
| New F | New Patient · F2 New Patient Using a Template · F3 Find Patient · F4 Claim Archives · F5 Enter New Claim Charges · F6 Exit · F10 Patient/Insured Info Physician/Diagnostic Info New Charges: \$210.00 4/8/2009 | | | | | | | | | | | | | | | | |
| 1 duoi | Patient/Insured Initio Physician/Diagnostic Initio New Charges Charges, \$210,00,47022003 Patient Name: SAMPLE, PATIENT Claim ID: 7 Not Printed Beports Print 1500 | | | | | | | | | | | | | | | | |
| | S M | 4ay-2009 T ₩ T | FS | S | Ju M T | ine- `\₩ | 2009 / T | F | s | S | Jul M T | y-2 ₩ | 009 T F | S | | <u>D</u> elete Cla | im 📗 |
| | 3 4 | 5 6 7 | 1 2 | | 1 2 | 3 | 4 | 5 | 6 | 5 | 6 7 | 1 | 2 3 | 4 | <u>S</u> a | ive As Tem | iplate |
| | 10 11 1 17 18 1 | 12 13 14 19 20 21 | 15 1 22 2 | 6 <u>14</u> 3 <u>21</u> | 15 1 22 2 | 6 17 3 24 | 7 18 4 25 | 19 2 26 2 | 20 27 | 12 19 | 13 14 20 21 | 15 22 | 16 17 23 24 | 7 18 4 25 | <u>O</u> pen | Template | Notes |
| | 24 25 2 31 | 26 27 28 | 29 3 | 0 28 | 29 3 |) | | | | 26 | 27 28 | 29 | 30 3. | 1 | Paid | | |
| | P <u>r</u> eviou | us Month | | Pre <u>v</u> ious | Patient | | | Ne <u>x</u> t P | atient | | (| Nex | t Month | | <u>B</u> ill D Prior | ate: Authorizat | ion No. |
| Defa | Diagnost ult Values | ic Codes: 1. | 3004 | 2. | | 3. | | | 4. | | | | | | | | |
| (Clic | k the calenda | ar to enter) | 11 | 9 | 0806 | | | 1 | | | \$70. | 00 | \$0.00 | 1 | | | |
| >> | From | То | Place | C EMG | PT/HCP(Procedur | CS e | Modifie | Di er | ag Co Line # | de | Charge | , | Applied Amt | E Units | PSDT Qu | Rend Pr al | ov ID |
| Del | 4/17/2009 | 4/17/2009 | 11 | 9 | 0806 | | | 1 | | | \$70. | 00 | \$0.00 | 1 | | | |
| Del | 4/24/2009 | 4/24/2009 | 11 | 9 | 0806 | | | 1 | | | \$70. | 00 | \$0.00 | 1 | | | _ |
| Del | 5/1/2009 | 5/1/2009 | 11 | 9 | 0806 | | | 1 | | | \$70. | 00 | \$0.00 | | | | _ |
| Del | | | | | | | | | | | | | | | | | |
| To To | itals On Last | Page Only | | | Tota | Cha | rge and | Amou | nt Paic | | \$210. | 00 | \$0 | .00 | Balance | \$21 | 0.00 |
| | | | | | | | | | | | _ | | | _ | | | |

Data entry tips

Box 21 - Enter diagnostic codes in the fields provided. (If you entered codes into the 'Claim Form Default' line on the **Physician/Diagnostic Info** screen, those codes will be automatically entered.)

• To enter Diagnostic codes, put your cursor in the box and enter code. Tab across the line to enter up to four DX codes.

Box 24a – Click on the calendar to select 'Date of Service'. If more than 6 dates of service are used, Form Filler will print multiple forms.

Box 24B - **Place of Service**: (Below are the most commonly used codes, contact your insurance company for additional codes)

- 11 Office
- 12 Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 24 Ambulatory Surgical Center
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance Land
- 42 Ambulance Air or Water
- 53 Community Mental Health Center
- 55 Residential Substance Abuse Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

Box 24C – EMG – Leave blank unless required by your insurance company.

Box 24D – Enter 'Procedure Code'. Enter the Modifier if required by your insurance company.

Box 24E - Enter the diagnostic code line number (POINTER) on the charges line. Do not use the actual diagnosis code in this box, 24E, only pointers. If payer accepts more than one pointer per service line, use single digits separated by commas or spaces (i.e. 1, 2).

Box 24 J

• **NPI** - If required by the insurance company, enter the Rendering Provider NPI number in the 'Rend Prov ID' field.

| >> | From | То | Place | EMG | CPT/HCPCS Procedure | Modifier | Diag Code Line # | Charge | Applied Amt | EP9 Units | DT Rend Prov ID Qual |
|-----|--|-----------|-------|-----|------------------------|----------|---------------------|---------|----------------|--------------|-------------------------|
| Del | 4/17/2009 | 4/17/2009 | 11 | | 90806 | | 1 | \$70.00 | \$0.00 | 1 | 0987654321 |
| Del | 4/24/2009 | 4/24/2009 | 11 | | 90806 | | 1 | \$70.00 | \$0.00 | 1 | |
| Del | 5/1/2009 | 5/1/2009 | 11 | | 90806 | | 1 | \$70.00 | \$0.00 | 1 | |
| Del | | | | | | | | | | | |
| Del | | | | | | | | | | | |
| Del | | | | | | | | | | | |
| Πī | Total Charge and Amount Paid \$210.00 Balance \$210.00 | | | | | | | | | | |

- **Provider (Legacy) Number** If your insurance company requires a **Provider ID#** <u>and</u> **NPI#** in 24J, enter data in the following format.
 - 1. Enter Qualifier in 'Qual' field. (See Qualifiers below)
 - 2. Enter the Provider number in the 'Rendering Prov ID or NPI' field.
 - 3. Enter an * and then the NPI number.

| | Applied | E | EPSDT | Rend Prov |
|---------|---------|-------|-------|--------------|
| Charge | Amt | Units | Qua | I ID or NPI |
| \$50.00 | \$0.00 | 1 | 1C | W4632*09876! |
| | | | | |

4. Both the Provider and the NPI numbers will then print in 24J of the 1500 form.

| I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|--------------------|-----------------------------------|
| 1C | W4632 |
| NPI | 0987654321 |
| | |

Qualifiers

Enter Provider ID qualifier in 241

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network ID Number
- SY Social Security Number
- X5 State Industrial Accident Provider Number

Line Item Descriptions

An insurance company may require a 'Line Item Description' to print in the shaded area above the line items in Box 24, see full EZClaim Form Filler manual under 'Charges Tab'.

Printing Claims – Step 6

Before printing your claims, see "Printer Adjustment" on page 2.

Single Claim: When you are finished entering date of service line items, confirm the CMS-1500 forms are in your printer and click the' *Print 1500*' button to print the claim.

Multiple Claims: To print multiple claims go to 'File' on the Menu bar>Select Claims to Print. Select by highlighting claims and then 'Print'.

Date Formats

When you print the claims, the dates are formatted according to the 'Print Settings' for each patient. Go to the Tools menu > Options > Print Options.

Printing a CMS-1500 form along with Data

Check the 'Print Form & Data' box at the lower right corner of the 'Patient/Insured Info' screen before printing your claim.