# CMS-1500 Billing Instructions

Line-by-line paper billing instructions
for Oregon Medicaid providers

Division of Medical Assistance Programs

Oregon Health Authority

# Overview

- This presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the CMS-1500 billing form correctly the first time.
- If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.
- We hope you find this tutorial helpful.

# Claims processing

- Paper claims are scanned into the claims processing system using Optical Character Recognition (OCR).
  - For OCR, you must use commercial "red form" claim forms and make sure certain fields are left-aligned.
- Electronic claims (Web and electronic data interchange) do not require specific claim forms or field alignment. Make sure you bill electronically whenever possible.
- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).

# Before you bill

- Verify client eligibility on the date of service.
  - AMH Licensed Residential Providers must verify Plan of Care to make sure to bill according to the plan.
- Make sure you bill all prior resources first. Medicaid (DMAP) is the payer of last resort.
- Bill electronically if possible. You only need to bill on paper if you need to submit attachments with your claim, the claim is over a year old, and other certain instances.
- If you must bill on paper, use commercially available "red form" versions of the current CMS-1500.

# Paper billing tips

- When submitting handwritten claim forms:
  - Use blue or black ink; never use red ink.
  - Make sure your handwriting is legible. Zeroes should look different from the letter “O,” the number one (“1”) different from the letter “I,” etc.
  - Don’t use liquid paper/whiteout to make corrections.
- If possible, submit no more than six lines of services per claim form.
  - If you need to bill more than six lines on a single claim, bill electronically. Then you don’t need to complete multiple paper claim forms.
- Check your printer alignment.

# Form suppliers

- DMAP does not supply the CMS-1500 form.
- You can purchase forms by contacting one of the following:
  - Local business forms suppliers
  - Oregon Medical Association (503-226-1555)
  - U.S. Government Printing Office (202-512-1800)
- If you don't want to purchase claim forms, you can use the Provider Web Portal for free!

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)

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

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 ______

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 | |

PHYSICIAN OR SUPPLIER INFORMATION

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

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

Division of Medical Assistance Programs

Oregon Health Authority

# 08-05 version

- Not sure if you are using the correct form?

The bottom right corner should say 08-05.

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

# Top section

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)

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

8. PATIENT STATUS Single Married Other

Employed Full-Time Student Part-Time Student

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

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

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? 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 ______

Red = Required

Yellow = Optional

# Box 1a - Required

| 1a. INSURED'S I.D. NUMBER | (For Program in Item 1) |
|---|---|
| X X # # # X # X | |

- Client ID Number
  - Enter the client's eight-character Oregon Medicaid identification number.
  - Enter the number exactly as it appears on the Oregon Health ID (formerly Medical Care ID) or the client's Plan of Care.

# Box 2 - Required

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

**Patient, Your**

- Patient's Name
  - Enter the client's name exactly as it is printed on the Oregon Health ID (formerly Medical Care ID) or the client's Plan of Care.
  - Use the client's last name first.
  - Do not use nicknames.

# Box 9 - Optional

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

NC

- Third Party Resource
  - If the client has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
  - A code must be listed when the other insurance did not make a payment.
  - A code is always required when the client has more than one other insurance carrier.
  - AMH Adult Residential Providers – Only enter “NC” in this field.
  - Other providers – See next slide for TPR codes.

# Single carrier TPR codes

| | |
|---|---|
| UD | Service under deductible |
| NC | Service not covered by insurance policy |
| PN | Patient not covered by insurance policy |
| IC | Insurance coverage canceled/terminated |
| IL | Insurance lapsed or not in effect on date of service |
| IP | Insurance payment went to policyholder |
| PP | Insurance payment went to patient |
| NA | Service not authorized or prior authorized by insurance |
| NE | Service not considered emergency by insurance |
| NP | Service not provided by primary care provider/facility |
| MB | Maximum benefits used for diagnosis/condition |
| RI | Requested information not received by insurance from patient |
| RP | Requested information not received by insurance from policyholder |
| MV | Motor Vehicle Accident Fund (MVAF) maximum benefits exhausted |
| AP | Insurance mandated under administrative/court order through an absent parent and not paid within 30 days |
| OT | Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance) |

# Multiple carrier TPR codes

| | |
|---|---|
| MP | Primary insurance paid – secondary paid |
| SU | Primary insurance paid – secondary under deductible |
| MU | Primary and secondary under deductible |
| PU | Primary insurance under deductible – secondary paid |
| SS | Primary insurance paid – secondary service not covered |
| SC | Primary insurance paid – secondary patient not covered |
| ST | Primary insurance paid – secondary canceled/terminated |
| SL | Primary insurance paid – secondary lapsed or not in effect |
| SP | Primary insurance paid – secondary payment went to patient |
| SH | Primary insurance paid – secondary payment went to policyholder |
| SA | Primary insurance paid – secondary denied – service not authorized |
| SE | Primary insurance paid – secondary denied – service not considered emergency |
| SF | Primary insurance paid – secondary denied – service not provided by primary care provider/facility |
| SM | Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition |
| SI | Primary insurance paid – secondary denied – requested information not received from policyholder |
| SR | Primary paid – Secondary denied – requested information not received from patient |
| MC | Service not covered by primary or secondary insurance |
| MO | Other (If above codes do not apply, include detailed explanation of why no TPR payment was made) |

# Box 10 - Optional

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

- Patient's Condition
  - Check the appropriate box only when an injury is involved.
  - Do not check any boxes if there is no injury to report.

# Middle section

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? $ CHARGES
YES NO

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

1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE
ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Red = Required

Yellow = Optional

# Box 17a - Optional

| 17a. | | ####### |
|---|---|---|

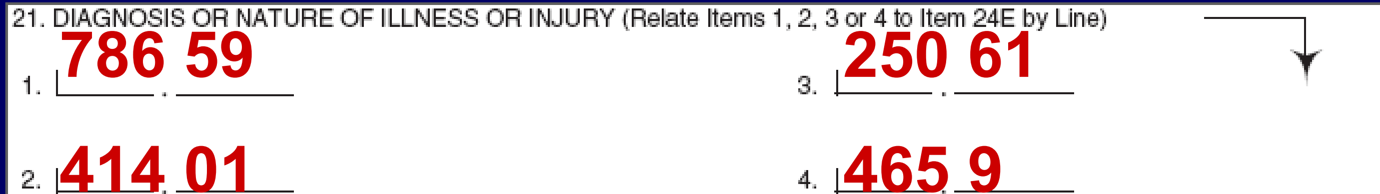
- Referring Provider Number
  - Enter the six (6)-or nine (9)-digit DMAP provider number of the referring provider.
- This may be required if the client has a Primary Care Manager (PCM) or the service requires a referral (*e.g.*, Physical Therapy, Occupational Therapy or Speech Therapy).
- This field is required for AMH Adult Residential Providers.

# Box 17b - Optional

| 17b. | NPI | ########## |
|---|---|---|

- National Provider Identifier (NPI) for referring provider
  - If you entered a DMAP provider in Box 17a (Primary Care Manager, or other referral), enter the 10-digit NPI registered under the DMAP provider ID used in Box 17a.
  - If you do not know what NPI to use, contact DMAP Provider Enrollment (800-422-5047).

# Box 21 - Required


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

1. 786 59
2. 414 01
3. 250 61
4. 465 9

- Diagnosis Code
  - Enter the ICD-9-CM code(s) for the client's diagnosis/condition.
  - The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
  - You may enter up to four codes and they must be carried out to the highest degree of specificity.
  - Do not enter a decimal point.
  - Note: Diagnosis codes are not required for transportation providers or AMH Adult Residential Providers.

# Box 23 - Optional

23. PRIOR AUTHORIZATION NUMBER

# # # # # # # # #

- Prior Authorization Number
  - If the service you provided requires prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
  - Only use one prior authorization number per claim form.
  - Do not bill prior authorized and non-authorized services on the same claim form.

# Bottom section

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.

Red = Required

Yellow = Optional

# Supplemental information – Optional

| 24. A. | DATE(S) OF SERVICE | | | | |
|---|---|---|---|---|---|
| | From | | | To | |
| MM | DD | YY | MM | DD | YY |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |

- In the shaded area above each detail line, enter additional information about the line item (*e.g.*, NDC).
  - If entering more than one item on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space.

# Supplemental qualifiers

Use when reporting the following services:

| Qualifier | Description |
| --- | --- |
| 7 | Anesthesia |
| ZZ | Narrative description of unspecified codes |
| VP | Vendor Product Number |
| OZ | Health Care Uniform Code |
| CTR | Contract rate |
| N4 | National Drug Code. Also use the following units of measure:<br>• F2 - International unit<br>• GR - Gram<br>• ML - Milliliter<br>• UN - Unit |

# Supplemental information examples

## National Drug Code

| 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. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N412345678901 UN1234.567 | | | | | | | | | | | | | | | 123456789 |
| MM | DD | YY | MM | DD | YY | 1 | | J##### | UD [for 340B drugs] | 1 | ### ## | 20 | | NPI | 1234567890 |

## Anesthesia Services, in 15-minute units

| 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. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7Begin 1245 End 1415 Time 90 Minutes | | | | | | | | | | | | | | | 123456 |
| 06 | 01 | 07 | 06 | 01 | 07 | 1 | | 00770 | P2 | 1 | ### ## | 6 | | NPI | 1234567890 |

## Unspecified Code

| 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. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ZZ Kaye Walker | | | | | | | | | | | | | | | 123456 |
| 06 | 01 | 07 | 06 | 01 | 07 | 4 | | E1399 | | 1 | ### ## | 1 | | NPI | 1234567890 |

## Vendor Product 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. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VPA122BIC5D6E7G | | | | | | | | | | | | | | | 123456 |
| 06 | 01 | 07 | 06 | 01 | 07 | 1 | | A6410 | | 1 | ## | ## | | NPI | 1234567890 |

# Box 24A - Required

24. A. DATE(S) OF SERVICE

| From MM | From DD | From YY | To MM | To DD | To YY |
|---|---|---|---|---|---|
| 12 | 01 | 08 | | | |
| 12 | 03 | 08 | | | |
| 12 | 05 | 08 | 12 | 06 | 08 |
| | | | | | |
| | | | | | |
| | | | | | |

- Date of Service
  - This box must list numeric dates.
  - If billing for one day, complete only the “from” column.
  - Only use From and To dates for a service given on consecutive days and provided no more than once a day.

# Box 24B - Required

| B. PLACE OF SERVICE |
| --- |
| 11 |
| 11 |
| 11 |

- Place of Service
  - Enter the two-digit CMS code for where the service was provided.
    - Adult foster homes use 12
    - Residential treatment facilities must use 56
  - CMS Place of Service codes are in CPT/HCPCS codebooks and on the CMS Web site at www.cms.hhs.gov/placeofservicecodes/downloads/posdatabase.pdf.

# Box 24C - Optional

C.
EMG
Y
N

- Emergency Flag
  - If the service you provided was a result of an emergency, enter a “Y” for “yes” in this box for each line item.
  - If this was not an emergent service, leave blank or enter a “N” for “non-emergent”.

# Box 24D - Required

| D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | | | |
|---|---|---|---|---|
| 99213 | 21 | | | |
| 99213 | 21 | | | |
| 99213 | 21 | | | |
| | | | | |
| | | | | |
| | | | | |

- Procedure Code
  - Enter the five-digit/ character CPT or HCPCS code(s) for the specific service provided.
  - Optional - Enter up to four two-digit national modifiers that relate to this service.
  - For procedure codes that indicate "unlisted," you must attach an operative/medical report.
  - AMH Adult Residential Providers should only bill using the codes on the next slide.

# Procedure codes and modifiers for AMH adult residential providers

| | |
|---|---|
| **Adult Foster Home** | Procedure S5141<br>Modifier HK |
| **Residential Treatment Home** | Procedure S5140<br>Modifier HK |
| **Residential Treatment Facility** | Procedure T2048<br>Modifier HK |
| **Secure Residential Treatment Facility** | Procedure T2048<br>Modifiers HK and TG |

# Box 24E - Required

| E. DIAGNOSIS POINTER |
| --- |
| 1 |
| 1 |
| 1 |
| |
| |
| |

- Diagnosis Pointer
  - Enter the one-digit diagnosis code reference number (pointer) as shown in box 21 to relate the date of service and the procedure performed to the primary diagnosis.
  - Do not enter the actual ICD-9-CM code here.

# Box 24F - Required

| F. $ CHARGES | |
|---|---|
| 93 | 00 |
| 93 | 00 |
| 186 | 00 |
| | |
| | |
| | |

- Total Charges
  - Enter the total usual and customary charge for each line.
  - Do not list credits.
  - Do not use dashes.
  - DMAP will not calculate your charge if billing for more than 1 item (unit).

# Box 24G - Required

G. DAYS OR UNITS

1

1

2

- Service Days or Units
  - Enter the number of days or units for each number of consecutive days or services as indicated in box 24A.
  - Some services are billed by units depending on the service provided.
  - For Adult Foster Homes, 1 unit = 1 month
  - For Residential Treatment, 1 unit =  1 day

# Box 24J - Optional

J.
RENDERING
PROVIDER ID. #

#######
###########

- Rendering Provider ID
  - Only required for AMH Adult Residential Providers, or when clinics or group practices use a specific billing provider number in Box 33.
  - Shaded - Enter the DMAP provider number of the rendering provider.
  - Non-shaded - Enter the NPI registered with the rendering DMAP provider ID.

# Box 26 - Optional

26. PATIENT'S ACCOUNT NO.

X123400

- Patient Account Number
  - Enter your patient account number here.
  - This box allows up to twelve characters.
  - This number will appear on your Remittance Advice (RA).

# Box 28 - Required

28. TOTAL CHARGE

$ 372 | 00

- Total Charge
  - Enter the total charge amount for all services listed in column 24F.
  - Each claim form is a separate document, and is to be totaled as such.

# Box 29 - Optional

29. AMOUNT PAID

$

- Amount Paid
  - Enter the total amount paid by any prior resource(s).
  - For AMH Adult Residential Providers, this includes client responsibility.
  - Do not include write-offs.
  - Do not include how much DMAP previously paid.
  - Do not include copayments.

# Box 30 - Required

| 30. BALANCE DUE | |
|---|---|
| $ 372 | 00 |

- Balance Due
  - Enter the balance due.
  - Box 28 minus Box 29 must equal Box 30.

# Box 33 - Required

33. BILLING PROVIDER INFO & PH # ( )
Billing Provider
PO Box ###
Anytown, OR 97###

a. ########### NPI | b. #######

- Billing Provider Information – Enter information for the provider number DMAP will direct payment to:
  - Box 33 - Enter the name and address of the billing provider.
  - 33a - Enter the NPI registered with the billing provider's DMAP ID number (listed in Box 33b).
  - 33b - Enter the billing provider's DMAP ID.
- Note: Non-medical services (*e.g.*, taxis) do not require NPI.

Completed CMS-1500 claim form

# EXAMPLES



Oregon Health Authority

# Medical Clinic

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): XX###X#X

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

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) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NC

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? YES NO PLACE (State)
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? 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. 786 59
2. 414 01
3. 250 61
4. 465 9

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 | 12 01 11 | | 11 | | 99213 | 21 | 1 | 93 00 | 1 | | NPI | ###### / ########### |
| 2 | 12 03 11 | | 11 | | 99213 | 21 | 1 | 93 00 | 1 | | NPI | ##### / ########### |
| 3 | 12 05 11 | 12 06 11 | 11 | | 99213 | 21 | 1 | 186 00 | 2 | | NPI | ##### / ########## |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: X123400

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

28. TOTAL CHARGE: $ 372 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 372 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.)

SIGNED ______ DATE ______

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

33. BILLING PROVIDER INFO & PH # ( )
Billing Provider
PO Box ###
Anytown, OR 97###
a. ########## b. ######

NUCC Instruction Manual available at: www.nucc.org

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

# AMH Adult Residential

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): **XX###X#X**

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

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) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): **NC**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? YES NO PLACE (State)
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? 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. **V62 9** 2. 3. 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| Line | 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 CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 04 | 01 | 09 | 04 | 30 | 09 | 12 | | S5141 | HK | 1 | 2730 60 | 1 | | NPI | ######### |
| 2 | | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | NPI | |

PHYSICIAN OR SUPPLIER INFORMATION

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 $ **2730 60**

29. AMOUNT PAID $

30. BALANCE DUE $ **2730 60**

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 # ( )
**Billing Provider**
**PO Box ###**
**Anytown, OR 97###**
a. NPI b. **#########**

NUCC Instruction Manual available at: www.nucc.org — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Division of Medical Assistance Programs

# Resources

| | |
|---|---|
| **Where to mail your claim** | DMAP<br>PO Box 14955<br>Salem, OR 97309-4955 |
| **Help with paper billing** | DMAP Provider Services<br>1-800-336-6016<br>E-mail: dmap.providerservices@state.or.us |
| **Provider Web Portal – Free paperless Web billing (for individual claims)** | https://www.or-medicaid.gov |
| **Electronic business practices (billing, payment and more)** | www.oregon.gov/DHS/healthplan/ebp.shtml |
| **Provider training** | www.oregon.gov/DHS/healthplan/tools_prov/training.shtml |

# THANK YOU!



Oregon Health Authority