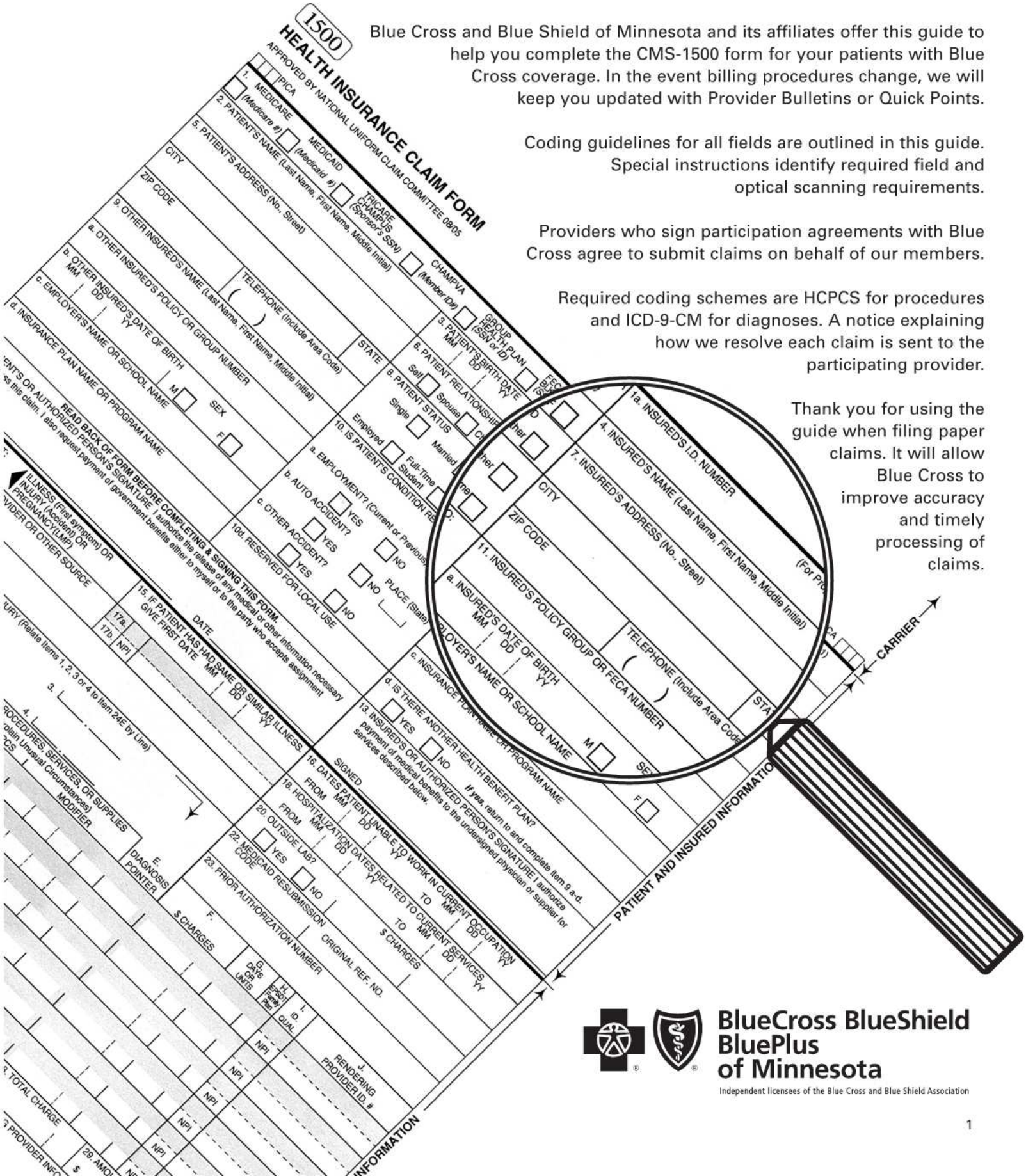
Guide for completing the CMS-1500 (Professional Claims) Form



Blue Cross and Blue Shield of Minnesota and its affiliates offer this guide to help you complete the CMS-1500 form for your patients with Blue Cross coverage. In the event billing procedures change, we will keep you updated with Provider Bulletins or Quick Points.

Coding guidelines for all fields are outlined in this guide. Special instructions identify required field and optical scanning requirements.

Providers who sign participation agreements with Blue Cross agree to submit claims on behalf of our members.

Required coding schemes are HCPCS for procedures and ICD-9-CM for diagnoses. A notice explaining how we resolve each claim is sent to the participating provider.

Thank you for using the guide when filing paper claims. It will allow Blue Cross to improve accuracy and timely processing of claims.

BlueCross BlueShield BluePlus of Minnesota

Independent licensees of the Blue Cross and Blue Shield Association

Required fields Required if applicable Not Used

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) ( )

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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. #
24A through 24G shaded section										
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For 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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

Completing the CMS-1500 Form

△ = Required ▲ = Required if applicable ○ = Not used

Field	Name and Number	Instructions
1 ▲	MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER	Place an "X" in the appropriate box for the type of health insurance applicable to this claim. If the "other" box contains an "X", complete field 1a with the primary coverage identification number. If secondary coverage, refer to field 9. Mark only one box.
1a △	Insured's I.D. number	Enter insured's ID number as shown on insured's ID card for the payer to whom the claim is being submitted. Do not include the patient's two-digit member number at the end of the ID.
2 △	Patient's name	Enter the patient's last name, first name and middle initial as it appears on the ID card.
3 △	Patient's birth date Sex	Enter the patient's eight-digit date of birth in (MM|DD|CCYY) format. Place an "X" in the appropriate box to indicate the patient's sex. Mark only one box. If gender is unknown, leave blank.
4 △	Insured's name	Enter insured's last name, first name and middle initial.
5 △	Patient's address	Enter the patient's address, city, state, zip code and phone number. If the patient's phone number is unknown leave blank. Do not use punctuation. Use two-digit state code and, if available, nine-digit zip code.
6 △	Patient relationship to insured	Place an "X" in the box for "self" if the patient is the insured, "spouse" if the patient is the insured's husband or wife. If none of the above applies, place an "X" to indicate "child" or "other" as applicable. Mark only one box.
7 ▲	Insured's address	Enter the insured's address, city, state, zip code and phone number. Do not use punctuation. If insured's address or telephone number is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code. **Note: For Worker's Compensation, use address of employer.**
8 ▲	Patient status	Place an "X" in the appropriate boxes. If the patient is a full-time student, complete field 11b if the information is available.
9 ▲	Other insured's name	When additional group health coverage exists, enter other insured's last name, first name and middle initial. **Enter the employee's group health insurance information for Worker's Compensation claims.**
9a ▲	Other insured's policy or group number	Enter the policy or group number of the other insured as indicated.
9b ▲	Other insured's date of birth Sex	Enter the other insured's eight-digit date of birth in (MM|DD|CCYY) format. Place an "X" in the appropriate box to indicate the other insured's sex. Mark only one box. If gender is unknown, leave blank.
9c ▲	Employer's name or school name	Enter the name of the other insured's employer or school.
9d ▲	Insurance plan name or program name	Enter the other insured's insurance plan or program name.
10 ▲	Is patient's condition related to: a. Employment (current or previous) b. Auto accident c. Other accident	Only one box can be marked per submission. a. Place an "X" in the appropriate box. If "yes", complete field 14. b. Place an "X" in the appropriate box. If "yes", indicate state and also complete field 14. c. Place an "X" in the appropriate box. If "yes", complete field 14.
10d ○	Reserved for local use	Not used.
11 ▲	Insured's policy group or FECA number	Enter the insured's policy or group number as it appears on the ID card if present. **For Worker's Compensation, enter the Worker's Compensation payer claim number if available.**
11a ▲	Insured's date of birth Sex	If known, enter the insured's eight-digit date of birth in (MM|DD|CCYY) format. If insured's date of birth is unknown, leave blank. Place an "X" in the appropriate box to indicate the insured's sex. Mark only one box. If gender is unknown, leave blank.
11b ▲	Employer's name or school name	Complete if full-time student. Enter the name of the insured's employer or school.

Field	Name and Number	Instructions △ = Required ▲ = Required if applicable ○ = Not used
11c ▲	Insurance plan name or program name	Enter the insurance plan or program name of the insured.
11d ▲	Is there another health benefit plan?	Place an "X" in the appropriate box. If "yes", complete fields 9a through 9d.
12 ▲	Patient's or authorized person's signature	Enter "Signature on File", "SOF" or legal signature. When legal signature, enter date signed.
13 ▲	Insured's or authorized person's signature	Enter "Signature on File", "SOF" or legal signature. This authorization will not be honored for in-state non-participating providers.
14 ▲	Date of current illness, injury, or pregnancy	Enter the first date in six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the first date. A date is required if injury or emergency.
15 ▲	If patient has had same or similar illness, give first date	Enter the first date in six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format that the patient had the same or similar illness. Previous pregnancies are not a similar illness. Leave blank if unknown.
16 ▲	Dates patient unable to work in current occupation	Enter dates patient is unable to work in six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format. Leave blank if unknown.
17 ▲	Name of referring physician or other source	Enter the name of the physician or other source that referred the patient to the billing provider or ordered the test(s) or item(s).
17a ▲ SHADED	Other ID #	Enter the two-character qualifier and Other ID. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.
17b ▲ UNSHADED	NPI	Enter the ten-digit NPI.
18 ▲	Hospitalization dates related to current services	Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) using the six-digit (MM|DD|YY) or eight-digit (MM|DD|CCYY) format. If not discharged, leave discharge date blank.
19 ○	Reserved for local use	Not used.
20 ▲	Outside lab? $Charges	For lab services enter an "X" in Yes if the reported service(s) was performed by an outside laboratory. If yes, enter the purchase price. Enter an "X" in No if outside lab service(s) is not included on the claim.
21 △	Diagnosis or nature of illness or injury	List up to four ICD-9-CM diagnosis codes. Relate lines 1,2,3,4 to lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this box.
22 ▲	Medicaid resubmission	For Medicaid resubmission claims only. Enter the correct three-digit replacement reason code followed by the 17-digit TCN of the most current incorrectly paid claim. Refer to Medicaid Manual for code list.
23 ▲	Prior authorization number	Enter the prior authorization or service agreement number as assigned by the payer for the current service.
24A–24G ▲ SHADED	Narrative Description	Enter the supplemental information in the shaded section of 24A through 24G above the corresponding service line. If an unlisted code is used, a narrative description must be present.
24A △ UNSHADED	Date(s) of service	Enter the six-digit date(s) of service in (MM|DD|YY) format. If one date of service only, enter that date under From. Leave To blank or re-enter From date. If grouping services, the place of service, procedure code, charge and rendering provider for each line must be identical for that service line. Grouping is allowed only if the number of days matches the number of units in 24G.
24B △ UNSHADED	Place of service	Enter the two-digit code from the place of service list in Appendix 2 in the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.
24C ▲ UNSHADED	EMG	EMG means emergency. Enter Y for "Yes" or leave blank for "No".
24D △ UNSHADED	Procedures, services, or supplies	Enter HCPCS Level I codes (CPT), Level II codes (A-DMEPOS) and modifiers. Up to four modifiers may be submitted.

Field	Name and Number	Instructions △ = Required ▲ = Required if applicable ○ = Not used
24E △ UNSHADED	Diagnosis code	Enter diagnosis pointer(s) referenced in field 21 to indicate which diagnosis code(s) apply to the related HCPCS code. Do not enter ICD-9-CM codes or narrative descriptions in this field. Do not use slashes, dashes, or commas between reference numbers.
24F △ UNSHADED	$ Charges	Enter the charge amount in (Dollars|Cents) format. If more than one date or unit is shown in field 24G, the dollar amount should reflect the TOTAL amount of the services. Do not indicate the balance due, patient liability, late charges/credits or a negative dollar line. Do not use decimals or dollar signs.
24G △ UNSHADED	Days or units	Enter the number of days or units on each line of service. When determining units refer to Appendix 3 in the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.
24H ▲ UNSHADED	EPSDT	If related to EPSDT enter Y for "Yes" with a valid referral code. If not related to EPSDT enter N for "No". For a list of valid EPSDT (C&TC) referral codes refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.
	Family Planning	If related to Family Planning, enter a Y for "Yes" or leave blank for "No".
24I ▲ SHADED	ID Qualifier	Enter the two-character qualifier. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.
24J ▲ SHADED	Rendering Provider ID	Enter the Other ID.
24J ▲ UNSHADED	Rendering Provider ID	Enter the ten-digit NPI.
25 △	Federal tax ID number	Enter your employer identification number (EIN) and place an "X" in the EIN box. If not available, enter your Social Security Number (SSN) and place an "X" in the SSN box. Only one box can be marked.
26 △	Patient's account number	Enter the patient's account number.
27 ▲	Accept assignment?	For patients with Medicare coverage, place an "X" in the appropriate box.
28 ▲	Total charge	Enter the sum of the charges in column 24F (lines 1-6). Enter the total charge amount in (Dollars|Cents) format. Do not use negative numbers.
29 ▲	Amount paid	Enter payment amount from the patient or other payer. An Explanation of Benefits may be required.
30 ▲	Balance due	Leave blank.
31 ▲	Signature of physician or supplier including degrees or credentials	Enter the signature of the physician, provider, supplier or representative with the degree, credentials, or title and the date signed.
32 ▲	Service facility location information	Enter the name and actual address of the organization of facility where services were rendered if other than box 33 or patient's home. Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code
32a ▲ UNSHADED	NPI	Enter the ten-digit NPI.
32b ▲ SHADED	Other ID	Enter the two-character qualifier and Other ID. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.
33 △	Billing provider info and phone number	Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code Name and address is required. Phone number is not required. If providing a phone number it must be entered in the area to the right of the box title. The area code is entered in parenthesis; do not use a hyphen or space as a separator.
33a ▲ UNSHADED	NPI	Enter the ten-digit NPI.
33b ▲ SHADED	Other ID	Enter the two-character qualifier and Other ID. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.

Optical Scanning instructions

Providers that are electronic claim submission enabled need to submit electronically. If you are unable to submit electronically, mail scannable paper claims. Blue Cross uses optical scanner technology to assist in the entry of paper claims into our processing system. Use of an optical scanner improves accuracy and timeliness of claims processing. Special instructions for completing the form are printed below.

- Providers must submit paper claims on the official (i.e., forms that meet Government Printing Office Specifications) Drop-Red-Ink CMS-1500 forms. We cannot accept black-and-white, faxed, or photocopied forms.
- Providers who preprint their names and addresses in field 33 should use a 10 or 12 point font size.
- Print:
  - Use UPPERCASE characters only
  - The print should be 10 or 12 point font size. Do not use multiple font sizes on a claim. This includes resubmissions with corrected information.
  - Use standard fonts- typewritten (Courier). Don't use unusual fonts such as sans serif, script, orator, italics, etc.
- Avoid old or worn print bands/ribbons. Claims that are too light cannot be scanned.
- Enter all information on the same horizontal line.
- Enter all information within the designated field.
- Do not hand-write, or stamp anything on the claim form.
- Pin-feed edges need to be removed evenly at side perforations.
- Avoid folding claims.
- A maximum of six line items are allowed per claim in field 24.
- Do not use special characters such as slashes, dashes, decimal points, dollar signs, or parentheses.
- Make sure the claim is aligned correctly and the data is within the box. If information is not contained within the intended field, it may be returned.
- Staple any multiple page claims (with or without attachments).
- If you are submitting a multiple page claim, enter the total claim amount only on the last page in field 28. Ensure patient, subscriber and provider information match exactly on preceding pages.

Service

The Provider Service department offers providers information about claims, benefits, payment, and Blue Cross and Blue Shield of Minnesota and Blue Plus procedures. Information can also be found on our provider web self-service site at **www.providerhub.com.**

Main office: (651) 662-5200 or 1-800-262-0820

Web site: www.bluecrossmn.com

BLUELINE: Voice-activated self-service tool that offers info by phone or fax. Call (651) 662-5200 or 1-800-262-0820.

Mail claims to:
Blue Cross and Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164-0338

To order CMS-1500 claim forms contact:
U.S. Government Printing Office at (202) 512-1800,
local printing companies in your area,
and/or office supply stores.

Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form:
The manual can be downloaded from the AUC web site at **www.health.state.mn.us/auc/manuals.htm.**