HCFA-1500 Form Completion
For the RLISYS ENSF Electronic Claims Software

2	Patient Name	Patient's name as Last Name, First Name (Example: Doe, John) **Do not include a prefix, suffix, or middle initial unless payer requires.**
5	Patient's Address	Patient's Street Address only. **Do not use punctuation such as periods, comma's, hyphens, or dashes.**
5	Patient's City	Patient's City
5	Patient's State	Patient's State Abbreviation
5	Patient's Zip Code	Patient's Zip Code
5	Patient's Telephone Number	Patient's Telephone Number
6	Patient Relationship to Insured	Self, Spouse, Child, or Other. Additional values may be selected on page 6 of the HCFA form. For example: If your insurance company requires the claim to have a more specific value rather than 'Other', you may select from 27 additional values on page 6.
3	Patient's Birth Date & Sex	Patient's Birth Date and Gender
8	Patient Marital Status	Single, Married, Other
8	Patient Student/Employment Status	Employed Full-Time, Full-time Student, Part Time Student Additional values may be selected on page 6 of the HCFA form.
1a	Insured's ID Number Also known as Subscriber ID	Insured or Subscriber's Policyholder Id number from the insurance card. **Do not use dashes or any other punctuation. Remove any punctuation already entered.**
4	Insured's Name also known as the **Subscriber's Name**	Insured or Subscriber's Last Name, First Name. (Example: Doe, John). **The Insured or Subscriber's Name is REQUIRED on all electronic claims.**
7	Insured's Address	Insured or Subscriber's Street Address. **Address is Required**. **Do not use any punctuation. Remove any punctuation already entered.**
7	Insured's City	Insured or Subscriber's City. **City is Required.**
7	Insured's State	Insured or Subscriber's State abbreviation. **State is Required**.
7	Insured's Zip	Insured or Subscriber's Zip Code. **Zip is Required**
7	Insured Telephone	Insured or Subscriber's Telephone number.

11	Insured's Policy/Group No	Generally, unless your payer has stated differently: For Medicare, enter the word None For Medicaid, leave box 11 blank. For DME, leave blank or enter the word 'None' whichever your DME payer requires. If you are not sure, call your Durable Medical Equipment Payer. For BCBS and/or Commercial Payers, enter a group number or leave blank if not required by the payer. If you are not certain whether you should use a group number, consult with your payer. **Do not use dashes or any other punctuation. Remove any punctuation already entered.**
11a	Insured's Date of Birth & Sex	Insured or Subscriber's Date of Birth and Sex **Required field.**
11b	Employer's Name or School Name	Leave blank
11c	Insurance Plan Name or Program Name	Leave blank
11d	Is there another health benefit plan?	Is there another Health Benefit Plan that is Primary to Medicare? Leave blank.
9	Other Insured's Name	Other Insured or Subscriber's Last Name, First Name Example: (Doe, John) Used only if the patient or the Insured has a Medigap policy. If the secondary insurance company is an automatic crossover, leave this field blank.
9a	Other Insured's Policy or Group Number	Other Insured or Subscriber's ID number with the secondary insurance. Used only if the patient has secondary insurance to Medicare and the secondary insurance is not an automatic crossover. If the secondary insurance company is an automatic crossover, leave this field blank. **Do not use dashes or any other punctuation. Remove any punctuation already entered.**
9b	Other Insured's Birth Date & Sex	Other Insured or Subscriber's Date of Birth and Sex. Used only if the patient has secondary insurance to Medicare and the secondary insurance is not an automatic crossover. If the secondary insurance company is an automatic crossover, leave this field blank. **This field is required if Boxes 9 and 9a are filled.**
9c	Employer's Name or School Name	Leave blank
9d	Insurance Plan Name or Program Name	Leave blank.
10	Is Condition Related to	Employment, Auto Accident, or Other Accident is only selected if applicable; otherwise leave blank.

10a	Employment?	
10b	Auto Accident? State	If Auto Accident is selected, State is required.
10c	Other Accident?	
10d	Reserved	Not used for electronic claims.
12	Medical Release? Release Date	Medical Release date is a required field for electronic claims and must be selected. The release date is the date the patient gave written authorization to submit the claim form.
13	Insured Signature on File?	Insured's or Subscriber's Authorization Release. Must be completed if Medigap is included on the claim form.
14	Date of Current Illness or Injury	Date when symptoms first began for current illness, injury, or pregnancy. **This is a required field for electronic claims**.
15	First Date of Similar Illness or Injury	Enter date when the patient first consulted a physician for a similar condition.
16	Dates Unable to Work	Enter dates that patient is unable to work in his or her current occupation.
18	Dates of Hospitalization	Enter date when a medical service was furnished as a result of a related hospitalization.
17	Referring Physician	When completing a claim form, follow your payer's instructions precisely. If you are unsure when to use a referring physician, consult your payer instruction manual, call the payer, or go to the payer website and search for the criteria. Referring Physicians may be customized in the RLISYS Customization>Referring Physician Menu>Add Referring Physicians. When a Referring Physician Name is entered or selected in box 17, the UPIN must also be entered in 17a. All Durable Medical Equipment (DME) claims must contain the Ordering Physician Name in box 17 and the UPIN number in 17a or the claim will be rejected. **Referring or Ordering Physician's Name must appear as:** **Last Name, First Name (Smith, Joe). If the referring physician contains any other values other than Last Name, First Name, the claim will be rejected.** **Example:** **Correct: Doe, John** **Incorrect: Doe, John M. OD**
17a	Referring Phys ID	The unique physician identification number of the referring physician. For a claim form completed for Medicare where a UPIN number is required, the UPIN number is 1 letter followed immediately by 5 numbers. *Note: There are payers other than Medicare and DME that require a number be entered into 17a. Please note that if you enter a number in 17a, you must enter a name in 17.* **Do not use punctuation - no spaces, no dashes. The UPIN number should appear as a letter immediately followed by 5 numbers.** **When entering UPIN numbers, do not confuse the letter O with a zero, as this will create a rejected claim.**

19	Reserved for Local Use	For paper claims, payers instruct that additional information be entered in box 19. **However, for electronic claims, leave box 19 blank. Any additional information, such as postoperative services, will be entered on page 7 of the Electronic Information Menu, which is designed specifically for electronic claim filers.** **Leave blank**
20	Outside Lab? Lab Charges	Complete this item when billing for diagnostic tests subject to purchase price limitations.
21	Diagnosis or Nature of Illness or Injury	At least one diagnosis code is required on a claim form. The ICD-9 code or diagnosis code must be valid.
	RFV	Reason for Visit Code.
24e	Diagnosis No	Diagnosis Pointers A pointer to the claim diagnosis code in the order of importance to this service. **Note: When entering pointers, use 1000, 2000, 1200, 1230, 1234, etc. The pointer field should always contain a 4-digit number.**
24a	Dates of Service	Service From and Service To dates. Both dates must be entered for electronic claims.
24b	Place of Service	Always enter the National Place of Service Code.
24c	Type of Service Overwriting Type of Service Code	Always enter the National Type of Service Code if the Type of Service is required. Proprietary type of service codes, sometimes called Local Codes, are codes that have been created by a payer. These codes are not National or Standard codes. They are unique codes given by your payer and your state only and are not recognized by any other payer. Box 24c must always contain the National Standard Type of Service Code. However, because some payers still require non-standardized codes, you must overwrite the non-standardized codes in the Narrative, which is located on page 7 on the Electronic Information Menu. Example: Your state's Medicaid payer requires that you use a 10 as the type of service for exams. Box 24c: enter 01 as the type of service. 01 is a national standard code that any other entity would recognize. On the Narrative, page 7 you would enter TOS*10. TOS* informs the clearinghouse that you want the 01 type of service (which appears on page 4) overwritten with '10' before the clearinghouse sends the claim to the payer.
24d	Procedures, Services, or Supplies	CPT or HCPCS codes. Using CPT or HCPCS codes which have been deleted or that are invalid will result in a rejection on your electronic claim. The Exclusion report will state: Invalid Procedure Code.
	CPT	Acronym for Current Procedure Terminology. CPT codes are numeric codes, such as 92004 or 92002. CPT codes are updated yearly so it is

		critical that you maintain the updated codes.
	HCPCS	Acronym for Healthcare Common Procedure Coding System. HCPCS are codes that begin with a letter followed by 4 numerics, such as V2020 or V2025. HCPCS are updated yearly as well.
	Modifiers	Modifiers further qualify the service or procedure. For example: 55 is the qualifier that should be used for postoperative management procedures. Modifiers, like the CPT and HCPCS codes, are updated yearly. 3 modifiers may be entered on the HCFA form.
24g	Days or Units	001 is the default. 001 means that only 1 service was performed. Please consult your insurance manual or payer instructions when the days or units need to be changed. **Note: When changing the days or units, ensure that this field contains 3 characters. Example 003, 030.**
24H	EPSDT/Family Plan	May contain a Y, N or blank as determined by your payer. **The default for EPSDT and Family Planning will be N.**
	EPSDT	Early Periodic Screen for Diagnosis and Treatment of Children
	Family Plan	Indicates whether services for family planning are involved.
24I	Emergency	Emergency related indicator: Y value indicates that the service provided was emergency related. If the service provided was not emergency related, this field will be blank. You may change the emergency indicator on the HCFA form at any time. **The default for Emergency will be blank.**
24J	COB	Currently, not applicable
24K	Reserved for Local Use New rendering provider number procedure:	Not applicable. For paper claims, this is usually the rendering provider's number. For electronic claims, the Rendering Provider number is not taken from 24K. The Rendering Provider number is taken from the electronic claims software only. **24k is NOT applicable for electronic claims since the rendering provider number is taken from the electronic claims software.**
25	Federal Tax ID	Employers Identification number or Social Security number. When you enrolled with the payer, the payer instructed you to use either- the EIN or SSN. If you are unsure, please call the payer. **The Federal Tax Id number (box 25) is NOT applicable for electronic claims since the Federal Tax Id number is taken from the electronic claims software.**
26	Patient Account No	Not applicable
27	Accept Assignment	Y or N **The default will be Y**.
28	Total Charge	RLISYS will automatically calculate the total charge.
29	Amount Paid	**Patient Amount Paid**
30	Balance Due	RLISYS calculation: total charges less patient amount paid
31	Signature of Physician or Supplier	Defaults the name of the provider that you selected to complete the claim form.

32	Name and Address of Facility where Services were Rendered (if other than home or office)	If the service was not rendered in your office (Place of Service 11), use a facility. If your Medicare payer has notified you to use a facility even when the service was rendered in your office, then you must use a facility. Generally, when a QB* or QU* modifier is used, a facility is required. *QB is the qualifier meaning Physician providing service in a rural Health Professional Shortage Area (HPSA). *QU is the qualifier meaning Physician providing service in an urban Health Professional Shortage Area (HPSA). If the place of service is 12 (Home), you do not have to enter a facility. Please advise the RLISYS trainers if you need to use facilities. We will assist you in creating a 1 to 3-character code that will represent the facility name and address. The benefit to you is that you will not have to manually type the facility name and address in box 32 for each claim. You will simply enter the 1 to 3 character code that represents the facility Name and Address. **You must advise your trainer if you use Facilities so that facilities may be customized.**
33	Physician, Supplier Billing Name, Address, Zip Code & Phone Number Pin # Group #	While this is critical information on a Paper claim, it is Not Applicable for Electronic claims. The Group Name, Provider or Supplier Name, Address, & Phone Number, Pin or Group number does not pull from 33. All of this information is pulled from the electronic claims software. If your payer assigns a new group or rendering provider number, the new group or rendering provider number must be entered in the electronic claims software. **Changing box 33 will not correct the provider numbers on your electronic claims.** **Box 33 is NOT APPLICABLE for Electronic Claims**
	Electronic Information page 6	Page 6 has been created by RLISYS in order to provide you with the additional information that is conditionally required for electronic claims that does not appear on the HCFA claim form.
	Referring Physician ID	If you selected a referring physician in box 17, the first 4 letters of the last name should be displayed. If you are completing a DME claim (for glasses), an * followed by the first 3 characters of the last name will be displayed. The referring or ordering physician's name will be displayed as Last Name, First Name. If you did not select a referring or ordering physician in box 17, this field will be blank.
	Referring Physician Address, City, State, Zip	The Referring Physician address is not currently required by any payers. However, if the referring address becomes a required field, the address may be customized in RLISYS (Customize Referring Physicians) and will then be displayed.

	UPIN #	If a referring or ordering physician was selected in box 17, the UPIN # for that referring or ordering provider will be displayed; otherwise, UPIN # will be blank.
	Info Code Release	Information Code Release is how the provider obtained permission to release medical information contained in the claim. Electronically, there are 6 options. The default for this field is Yes; however, you may select any value required by your payer from the dropdown menu. **Yes, provider has a signed statement permitting release of medical information is the default.**
	Accept Assignment	In box 27, Accept Assignment, there are only 2 options - yes or no. Electronically, there are 4 options. Please review all of the options in the dropdown list. If you have selected Yes in box 27, this field will display A for assigned. If you select No in box 27, this field will display C for not assigned
	Patient Relationship to Insured	Box 6, Patient Relationship to Insured contains Self, Spouse, Child, and Other. If you need to be more specific than selecting the option 'Other' from box 6, there are 27 values in the dropdown that may be selected. **However, unless the payer requires a more specific relationship, continue to select Other in box 6.**
	Patient Employment Status	Box 8 Patient Status has one employment option, which is Employed, Status Unknown. If you need to select a different option, you may select 7 different options from the dropdown.
	Insured's Employment Status	There is no field or box on the HCFA claim form for Insured's Employment Status. If the payer requires this information, you may select 7 different options from the dropdown.
	Signature Source	This field describes whether box 12 (Medical Release) and /or box 13 (Insured's Signature on File) have been checked. If box 12 and 13 are checked, the Signature Source will display B Signed for Block 12 and 13. There are 5 options to choose for electronic claims. Please review these options.
	Assumed Date	Required on all Medicare claims to indicate assumed care date for situations where providers share postoperative care (global surgery claims).
	Relinquished Date	Required on all Medicare claims to indicate relinquished care date for situations where providers share postoperative care (global surgery claims).
	Vision Rx Date	If the payer requires the Vision Rx Date for claims where a prescription has been written for vision frames and lenses and it is being billed on the claim. If the payer does not require this information, leave it blank.
	Referral Date	Enter the Referral Date if the payer requires; otherwise, leave blank.
	Referral Number	There are thousands of payers and each payer seems to require a Referral Number in different places on the HCFA claim form. Some payers require you to enter the referral number in box 17a, UPIN, while other payers require the referral number in box 23, Prior

		Authorization. You must follow your payer's rules about Referral Numbers.
	Other Insured Payer (Medigaps)	Also known as Other Subscriber Payer or Medigap Payer.
	2nd Payer Name	Select the name of the Medigap payer from the dropdown. Medigaps must be customized in the RLISYS program AND the Electronic Claims Program before you may begin using. **You must have a recent Medigap listing and automatic crossover listing prior to customizing Medigaps. These are obtained from your Medicare payer.** **Please inform the electronic claims trainer if you would like to customize Medigap payers; otherwise, you will not be able to submit Medigap payers.**
	Elec Ins Type	In the RLISYS Customization, Insurer Information Menu, Add or Change Insurer Information, there is a field called Elec Ins Type (Electronic Insurance Type), which contains an option called 'Medigap Part B'. We highly recommend that you customize all of your Medigap payers with the insurance type, 'Medigap Part B' so that when you select a 2nd Payer Name, you will see the words 'Medigap Part B' under the Elec Ins Type heading. If you do not see 'Medigap Part B' under the Elec Ins Type heading, you have selected the wrong Medigap payer.
	Patient Relationship to Other Insured	When you are submitting a Medigap, the Patient's Relationship to the Other Insured is required. If you are currently not requesting this information on the Patient Insurance Data Sheet and the patient does have a Medigap, you will need to update the patient's file in order to file both insurances.
	Group Id Number	Leave this field blank. For future use.
	Address	Leave this field blank. For future use.
	City, State, Zip	Leave this field blank. For future use.
	Electronic Information page 7	Page 7 has been created by RLISYS in order to provide you with the additional information that is conditionally required for electronic claims that do not appear on the HCFA claim form.
	HA0	This field is specifically designed for North Carolina. North Carolina Medicaid requires Local Type of Service Codes. For example: the type of service code for Exams as directed by North Carolina Medicaid is 10. 10 is not a nationally recognized type of service code. For North Carolina Medicaid Exam claims, the Type of Service on page 4 must contain a 01 (a Nationally recognized type of service code). On page 7, you must click the HA0 dropdown, and select TOS*. TOS* means that the value following the * is the type of service code that you want the clearinghouse to send on the claim when they

		forward the claim to North Carolina Medicaid. You are, in essence, telling the clearinghouse to overwrite the 01 type of service code with the type of service code of 10. In the Narrative field next to the HA0 dropdown, you will enter 10.
	Narrative	This is the area where you record additional information that the payer requires. It is the equivalent of box 19, Reserved for Local Use, for paper claims. When a payer instructs you to enter specific information in box 19 on the HCFA claim form, you will enter the required information in Narrative. (Box 19 Reserved for Local Use is not applicable to electronic claims) Since 1 claim may contain up to 6 line items (6 charges, 6 procedure codes) the claim may also contain up to 6 Narratives. You will notice that Narrative contains 6 lines. The first Narrative Line is the additional information for the first line item (on page 4). The second Narrative is for the second charge line item. The third Narrative is for the third line item and so on. **NOTE**: This would be a highly unusual situation where a payer would require special information in the form of a Narrative for each line item on page 4. Most electronic claim filers may just enter 1 Narrative which is appropriate for the entire claim. For example, a postoperative narrative, which consists of the postoperative period and the assumed or relinquished date applies to the entire claim. This type of information, which is required for a postoperative claim, may be entered on the first Narrative line. Subsequent Narrative lines would remain blank. Leave blank if you are filing for procedures that do not require a Narrative. **Note: The first Narrative line is the equivalent of box 19, Reserved for Local Use, for paper claims. This is where additional information must be entered if directed by the payer. You have up to 6 narrative lines because you can have up to 6 procedures on a claim. If there is only 1 procedure code on your claim you can only use the first narrative line.**
	Note Ref Code	If you entered additional information in the Narrative, you must select ADD from the Note Ref Code dropdown. If you do not select Add, the Narrative will not be included in the claim.
	DME CMN Ind.	This field is also known as the Report Transmission Code. Code indicating the title or contents of a document, report, or

		supporting information. The code actually identifies the timing and transmission method by which reports are to be sent. DME CMN Indicator is only used if your payer states that it is required for the type of claim being submitted.
	Report Type Code	Code that identifies documentation or paperwork that is being held at the provider's office and is available upon request by the payer, but that is not being sent with the claim. You may select up to 5 Report Type Codes. Example: Code B4 = Referral Form Code B2 = Prescription **Unless your payer requests this code, leave blank.**
	Attachment Code	Code that represents how you are sending the additional documentation or paperwork reported in Report Type Code. If you have selected the Report Type Codes, Code B4 (Referral Form) and Code B2 (Prescription), you must select 2 Attachment Codes. Examples of Attachment Codes are: Code FX = By Fax Code BM = By Mail **If you have selected a Report Type Code, you must select an Attachment Code.**
	Attachment #	Number on the documentation or paperwork that you reported in the Report Type Code. For instance, if you selected Code B2 for Prescription, the Attachment Number would be the Rx number. If the document or paperwork does not have an identifying number, you may leave this field blank.
	Rx	The Rx section should be completed when filing a claim to Clarity Vision or any other payer that requires Patient Condition Information on Vision.
	Condition Category	Code that represents the items supplied. You may include all 3 condition categories on 1 claim for Clarity Vision. E1 = Spectacle Lenses E2 = Contact Lenses E3 = Spectacle Frames
	Condition Code 1	Code indicating a condition: L1 General Standards of 20degree or .5 diopter sphere or cylinder change met L2 Replacement due to loss or theft L3 Replacement due to breakage or damage L4 Replacement due to patient preference L5 Replacement due to medical reason Example: You selected the Condition Category E1 (Spectacle Lenses). You must now show the reason for the replacement or the Condition Category code. If the lenses were replaced due to breakage, you would select L3 from the dropdown. You may select more than 1 Condition Code for a category.

	Indicator	Checking the Indicator field means that the code that you selected in Condition Code applies. If you do not check the Indicator checkbox, the Condition Code that you selected does not apply.

The first condition category is E1 Spectacle Lenses

The condition code is L1 general standard of 20degrees or .5 diopter in sphere or cylinder has been met.

I have checked the Indicator checkbox to specify that the general standards have been met.

If the Indicator is not checked, then the general standards have not been met.