CMS-1500 Billing Guide for PROMISe™ Hospice Providers

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:

- **Hospice – Provider Type 06**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:
  - **M** – Indicates that the claim block must be completed.
  - **A** – Indicates that the claim block must be completed, if applicable.
  - **O** – Indicates that the claim block is optional.
  - **LB** – Indicates that the claim block should be left blank.

*** –** Indicates special instruction for block completion.

- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2: **Font Sizes —** Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24F ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24F, enter your usual charge, without a decimal point. You must include the dollars and cents. If your usual charge is thirty-five dollars, enter:

24F	
$CHARGES	
35	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

ACCESS Plus MA Bulletin 99-06-11 (Implementation of ACCESS Plus Referral Requirements) notified providers that MA will begin enforcing ACCESS Plus referral requirements for dates of service on or after November 1, 2006.

When submitting claims for services rendered to an ACCESS Plus-enrolled recipient who is referred by their ACCESS Plus Primary Care Physician (PCP) via the CMS-1500 claim form, providers must include the referring ACCESS Plus PCP's 13-digit provider number in Block 17A.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

You must follow these instructions to complete the CMS-1500 claim form when billing the Department of Public Welfare. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to DPW.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit recipient number found on the ACCESS card. If the recipient number is not available, access the Eligibility Verification System (EVS) by using the recipient's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit recipient number to use for this block.
2	Patient's Name	O	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.
3	Patient's Birthdate and Sex	O	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to the Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
8	Patient Status	O	Place an **X** in the appropriate blocks to describe the patient's status.
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy and Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a-d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9a-d, if you have completed Blocks 11a-d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Other Insured's Date of Birth and Sex	A	If a secondary insurance exists, enter the other insured's date of birth. Please make sure the date is in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and indicate the patient's gender by placing an **X** in the appropriate box.
9c	Employer's Name or School Name	A	Enter the name of the other insured's employer.
9d	Insurance Plan Name or Group Name	A	Enter the other insured's insurance plan name or group name.
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's two-letter postal code for the state in which the accident occurred in the PLACE block (e.g., **PA** for Pennsylvania).

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
10d	Reserved For Local Use	O	Enter the 9-digit social security number of the policyholder if the policyholder is not the recipient.
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3.
11b	Employer's Name or School Name	A	Enter the name of the other insured's employer for the primary insurance.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9a-d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The recipient's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) **Note:** Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
14	Date of Current:	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).
15	If Patient Has Had Same or Similar Illness	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Physician or Other Source	M	Enter the name and degree of the referring or prescribing practitioner, when applicable. **Services Requiring an ACCESS Plus PCP Referral:** If the service provided requires a referral from the recipient's ACCESS Plus Primary Care Physician (PCP) and the recipient's ACCESS Plus PCP referred the recipient for the service, enter the name of the ACCESS Plus PCP.
17A	I.D. Number of Referring Physician	M	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number **1D** = 13-digit Provider ID number (Legacy Number) In the second portion, enter the **license number** of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456). If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six 9's, and an

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
			X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X. **Services Requiring an ACCESS Plus PCP Referral:** If the service provided requires a referral from the recipient's ACCESS Plus Primary Care Physician (PCP), and the recipient's ACCESS Plus PCP referred the recipient for the service, enter the PCP's 13-digit Provider Number (i.e., referral code).
17b	NPI #	M	Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source.
18	Hospitalization Dates Related to Current Services	A	Complete only if the patient was hospitalized in an inpatient setting. Make sure the dates are in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004). Providers may submit a bill prior to a patient's discharge by entering the admission date and eight zeros in the discharge date. If you submit an interim bill, submit the final claim for any remaining inpatient visits by completing the admission date and entering the actual discharge date.
19	Reserved For Local Use	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**", followed by a two-digit number (i.e., **AT05**). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**", indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form. When using "**AT10**", indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form. Attachment Type Code "**AT99"** indicates that remarks are

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
			attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the recipient's number on the top left-hand corner of the page (i.e., Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's recipient number. On the remarks sheet, include the mother's full name, date of birth, and social security number.). If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. *For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.* *For additional information on completing CMS-1500 claim form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*
		A	**Qualified Small Businesses** Qualified small businesses must always enter the following message in Block 19 (Reserved for Local Use) of the CMS-1500, in addition to any applicable attachment type codes: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
***Note:** If the recipient has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim.			
20	Outside Lab?	LB	Do not complete this block.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
21	Diagnosis or Nature of Illness or Injury	M/A	Enter the most specific three-, four-, or five-digit ICD-9-CM code that describes the diagnosis. The primary ICD-9-CM code block (21.1) must be completed. The second, third, and fourth diagnosis codes must be completed if applicable.
22	Medicaid Resubmission	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the two-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	A	If applicable, enter the 10-digit prior authorization number. Refer to Section 7 of the CMS-1500 Claim Form Provider Handbook for additional information regarding prior authorization and your specific provider type.
24a	Dates of Service	M/M	Enter the applicable date(s) of service. If billing for a service that was provided on one day only, complete either the **From** or the **To** column (but not both.). If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
24b	Place of Service	M	Enter the two-digit place of service code that indicates where the service was performed. **11** – Office **12** – Home **21** – Inpatient **32** – Nursing Facility **34** - Hospice
24c	EMG	LB	Do not complete this block**.**
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second and third sections of the block, enter up to four applicable modifiers. *For compensable procedure code modifier combinations, please refer to the PA* PROMISe™ *fee schedule accessible via the DPW Internet site.*
24e	Diagnosis Pointer	M	This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 21), enter **1**. If provided for the secondary diagnosis, enter **2**. If provided for the third diagnosis, enter **3**, and for the fourth diagnosis, enter **4.**
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24g	Days or Units	M	Enter the number of units, services, or items provided.
24h	EPSDT/Family Planning	A	Enter the two-digit Visit Code, if applicable. Visit Codes are especially important if providing services that do not require copay (i.e., for a pregnant recipient or long term care resident.)

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
			For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **1D** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	M	Enter the 10-digit NPI number of the rendering provider.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to ten alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect recipient number is listed.
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	A	If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. **Do not enter copay in this block.**
30	Balance Due	LB	Do not complete this block.

CMS-1500 Claim Form Completion for PROMISe™ Hospice Providers

Block No.	Block Name	Block Code	Notes
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004).
32	Service Facility Location Information	A/A	If the service(s) was provided in an inpatient hospital setting, enter the name of the hospital and nine-digit provider identification and four-digit service location of the facility. **Do not use slashes, hyphens, or spaces**. If the service(s) was provided in a long term care facility, enter only the name of the facility.
32a		M	Enter the 10-digit NPI number of the service facility.
32b		M/A	Enter the 13-digit facility Provider ID number (Legacy #)
33	Billing Provider Info & Ph.#	A/A& M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)