CMS 1500 Claim Form

FIELD NAME	INSTRUCTIONS
1. Coverage Indicator	Enter an "X" in the appropriate box.
1a. Insured's ID Number	Enter the patient's nine-digit Medical Assistance identification number (SSN).
2. Patient's Name	Enter the recipient's name, exactly as it is spelled on the Medical Assistance ID card.
3. Patient's Birthdate/Sex	Enter the patient's date of birth in MMDDYY format and the patient's sex.
5. Patient's Address	Enter the street, city, state and zip code of the patient.
9d. Insurance Plan Name	Enter the three digit carrier code and name of any other insurance the patient has. **Note**: The other insurance carrier must be billed first.
10. Condition Related	If the illness or injury is employment related, mark the appropriate box in 10A. Mark 10b "Yes," if the condition is due to an auto-accident and enter the two letter Postal Service code for the state in which the auto accident occurred. If the condition is related to some other accident mark the appropriate box in 10c. Enter the date of the accident or illness in 10d.
11d. Another Health Benefit Plan	Check Yes or No to indicate whether or not the services are covered by any other insurance**. (Yes must be checked if other insurance is listed in form locator 9d.)**
12. Patient's or Authorized Person's Signature	Enter patient's signature, or "Signature on File." If "Signature on File" is entered, provider must maintain the original patient signature in provider's file.

17. Name of Referring Physician	Enter the name of the physician who referred this patient for these services. **Required for consultations.**
17a. Referring Physician ID	Enter the qualifier 1D – Medicaid Provider Number of the referring physician named in form locator 17. Enter qualifier ZZ - Taxonomy code if NPI is entered in 17b**. Taxonomy is required if NPI is entered in 17b.**
17b. Referring Physician NPI	Enter the referring physician NPI number if 17 A is ZZ.
18. Hospitalization Dates	Enter the date(s) the patient was in a hospital for any related service (in MMDDYY format).
19. Reserved for Local Use (Referred Provider - EPSDT Only	Enter the Medical Assistance or other provider number of the medical provider to whom the patient is referred for treatment. Also enter the HCPCS procedure code that indicates the need for referral or treatment. (**Note**: This form locator is only required for EPSDT referral services.)
20. Outside Lab	Check the "Yes" or "No" box, as appropriate, to indicate whether the provider sent laboratory work out to be processed. **This field is required when billing for a laboratory service**.
21. Diagnosis	Enter up to four ICD-9-CM diagnoses codes that describe the illness or injury for which the patient is being treated.
24a. Date(s) of Service	Enter the From and To date(s) for this service in MMDDYY numeric format. If there is only one date for this service, leave the To date blank. For reporting in shaded area, the appropriate qualifier should be entered.
24b. Place of Service	Enter the appropriate place of service code for each service from the following list: 01 - Pharmacy 03 - School 04 - Homeless Shelter 05- Indian Health Center - Freestanding 06- Indian Health Center – Provider Based

	09- Correctional Facility 11 - Office 12 - Home 13 - Assisted Living 14 – Group Home 15 – Mobile Unit 20 – Urgent Care Facility 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room 24 - Ambulatory Surgical Center 31 - Skilled Nursing Center 32 - Nursing Facility 33 – Custodial Care Facility 34 - Hospice 41 - Ambulance 42 – Ambulance Air 50 – Federally Qualified Health Center 51 - Inpatient Psychiatric Facility 53 - Community Mental Health Center 54 - Intermediate Care Facility/ Mentally Retarded 55 - Residential Substance Abuse Treatment Facility 56 - Psychiatric Residential Treatment Center 57 – Non – Residential Treatment Facility 60 – Mass Immunization 61 - Comprehensive Inpatient Rehabilitation Facility (CIRF) 62 - Comprehensive Outpatient Rehabilitation Facility (CORF) 65 – End Stage Renal Dialysis 71 – Public Health Clinic 72 - Rural Health Clinic 81 - Independent Laboratory 99 - Other Listed Facility

24c.Emergency Indicator	Enter Y if emergency or blank if not.
24d. Procedure Code	Enter the 5 character HCPCS code that describes each procedure performed in the un-shaded area. Also enter the modifier (up to four, if any) that apply to each procedure code. **HCPC must be entered in un-shaded fields.** **An NDC is required if an (injectable) code is billed.** Enter the N4 qualifier immediately followed by the 11 digit NDC in the shaded area of 24A followed immediately by the two digit unit of measurement and the number of units (five digits a decimal and three spaces after the decimal) . Units of Measurement FL - International Unit GR - Gram ML - Milliliter UN - Unit(s) To report more than one NDC per HCPC use the NDC attachment form.
24e. Diagnosis Code	Enter "1," "2," "3" and/or "4" to reference one or more of the diagnoses codes from form locator 21 to the procedure code(s) listed in form locator 24D. Up to four diagnoses codes can be entered for each detail line.
24f. Charges	Enter the UCR amount charged for each procedure performed. (If a service was performed on consecutive days, enter the <u>total</u> charge for the procedure).
24g. Days or Units	Enter the number of days or units rendered for each service performed or mileage if appropriate.
24h. EPSDT/Family Planning	Enter "E" if this claim is related to, or was a referral for, EPSDT services. Enter "F" if the procedure billed is Family Planning-related. Enter "B" if it is both EPSDT and Family Planning-related. **This field is required when providing an EPSDT service.**
24i. Rendering Provider ID Qualifier	**Required if the billing provider is a group.** Shaded area enter qualifier 1D – Medicaid Provider

	Number or ZZ – Taxonomy. **Taxonomy is required if NPI is entered in 24J, unshaded area.**
24j. Rendering Provider ID	Medicaid Provider Number of the rendering provider in shaded area if 24i is 1D. Enter Taxonomy code if NPI is entered in the unshaded area of 24i. **Taxonomy is required if NPI is entered in 24i.**
26. Patient's Account Number	Enter up to 14 numbers and/or letters that the provider uses to identify the patient. This identifier is not used in claim processing, but will appear on your Remittance Advice (RA) to help identify the patient.
28. Total Charge	Enter the total of the charges for this claim, (the sum of the detail lines in Column 24F).
29. Amount Paid	Enter total amount paid by all other insurance companies toward the services rendered on this claim. **This field is required if "Yes" is checked in box 11d for other insurance.**
30. Balance Due	Enter the balance due from Medical Assistance. (Total Charge minus Amount Paid).
31. Signature	Enter the authorized signature of the billing provider or supplier on this claim. (Stamps or initials are not acceptable.) Also enter the date the claim is signed.
32. Name and Address of Facility Where Services Were Rendered	If the patient was seen in a location other than the patient's home or provider's office, enter the name and address of the facility where the services were rendered.
32a. NPI	Enter location NPI.
32b. Other ID	Enter 1D – Medicaid Provider Number, or ZZ – Taxonomy. **Taxonomy is required if NPI is entered in 32a.** i.e. 1D1234567 ZZ1234567890
33. Physician's or Supplier's Name, Address, Zip Code and	Enter the billing provider's name, address and Medical Assistance provider number.

Telephone Number	If this is a group practice or hospital/facility, enter that name, address and Medical Assistance provider number.
33a. NPI	Enter the NPI of the billing provider.
33b. Billing Provider ID	Enter the qualifier 1D – Medicaid Provider Number of the billing physician named in form locator 33. Enter qualifier ZZ - Taxonomy code if NPI is entered in 33a**. Taxonomy is required if NPI is entered in 33a.** i.e. 1D1234567 ZZ1234567890