BlueCross BlueShield of Illinois

A Guide for Completing the

CMS-1500 Form

TO ORDER CMS-1500 FORMS:

http://bookstore.gpo.gov

OR CALL:
(202) 512-1800

American Medical Association
P.O. Box 930876
Atlanta, GA 31193
(800) 621-8335

MAIL CLAIMS TO:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

Blue Cross and Blue Shield of Illinois offers this guide to help you complete the CMS-1500 form for your patients with BlueShield coverage.

Thank you for helping us to process your claims efficiently and accurately.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

00311.1205

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Me... #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — R

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) — R

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

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F — R

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — R

5. PATIENT'S ADDRESS (No., Street) — R

6. PATIENT RELATIONSHIP TO INSURED — Self | Spouse | Child | Other — R

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

CITY | STATE

8. PATIENT STATUS — Single | Married | Other — R

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) — C

10. IS PATIENT'S CONDITION RELATED TO: — R

11. INSURED'S POLICY GROUP OR FECA NUMBER — R

a. OTHER INSURED'S POLICY OR GROUP NUMBER — C

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F — O

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME — O

c. EMPLOYER'S NAME OR SCHOOL NAME — C

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME — O

d. INSURANCE PLAN NAME OR PROGRAM NAME — C

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — R 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. — O

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. — O

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — R

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE — C

17a. I.D. NUMBER OF REFERRING PHYSICIAN — C

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY — C

19. RESERVED FOR LOCAL USE — O

20. OUTSIDE LAB? YES NO — $ CHARGES — O

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) — R

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO. — O

23. PRIOR AUTHORIZATION NUMBER — O

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K PERFORMING PROVIDER STATE LICENSE #
1 — R	R	R	R	R	R	R	O	O	O	R
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN — R

26. PATIENT'S ACCOUNT NO. — O

27. ACCEPT ASSIGNMENT? (For gov... ms, see b... YES NO — R R

28. TOTAL CHARGE $ — R

29. AMOUNT PAID $ — C

30. BALANCE DUE $ — C

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.) — R

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) — R

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # — R

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Key

R REQUIRED IN FILING A BLUE SHIELD CLAIM
C CONDITIONAL --- ONLY IF APPROPRIATE TO THIS CLAIM
O OPTIONAL/NOT REQUIRED

1. **TYPE OF HEALTH INSURANCE COVERAGE** R
For services being billed to Blue Shield of Illinois place "X" in the box marked (OTHER).

1a. **INSURED ID NUMBER** R
Enter the Identification Number found on the subscriber's Blue Cross/Blue Shield Card.

2. **PATIENT'S NAME** R
Use no titles, punctuation, nicknames or special character,
Last name, First name, Middle initial i.e., Smith William E not Smith, Bill E.

3. **PATIENT'S BIRTH DATE/SEX** R
Enter the six digit date, (i.e., January 12, 1938 = 011238). Place "X" in appropriate box for patients' sex.

4. **INSURED'S NAME** R Last name, First name, Middle initial
Enter name of subscriber as listed on the Blue Cross/Blue Shield Card. Use no titles, punctuation, nick-name or special characters. i.e., Smith Margaret A not Smith, Peggy A.

5. **PATIENT'S ADDRESS/TELEPHONE NUMBER** R
Enter permanent mailing address and telephone number.
Street, City, State, Zip Code (Use no special characters or punctuation).

6. **PATIENT'S RELATIONSHIP TO THE INSURED** R
Place "X" in the appropriate box for patient's relationship to the insured.

7. **INSURED'S ADDRESS/TELEPHONE NUMBER** C
Street, City, State, Zip Code (complete if different than patient's address)

8. **PATIENT STATUS** R
Place "X" in the appropriate boxes.

9. **OTHER INSURED'S NAME** C
Last name, First name, Middle initial. When the patient has other insurance coverage complete 9 thru 9d. (This information is necessary to coordinate benefits with other insurance companies). Enter name of other insured.

9a. **OTHER INSURED'S POLICY OR GROUP NUMBER** C
Enter policy or group number of other insured (BlueShield: enter group and I.D. number).

9b. **OTHER INSURED'S DATE OF BIRTH AND SEX** C
Enter other insured's birth date. Enter six digit date, i.e., January 12, 1938 = 011238.
(Place "X" in appropriate box for sex.)

9c. **EMPLOYER'S NAME OR SCHOOL NAME** C
Enter other insured's employer or school.

9d. **INSURANCE PLAN NAME OR PROGRAM NAME** C
Enter name of other insured's insurance plan or program name.

10a-d. **IS PATIENT'S CONDITION RELATED TO**: R

10a. Place "X" in the appropriate box.

10b. Place "X" in the appropriate box and enter the state in which accident occurred, if appropriate. Use two character abbreviation, i.e., IL.

10c. Place "X" in the appropriate box.

10d. Not required in filing Blue Shield claims.

(11 thru 11d, refer to BCBS subscriber coverage)

11. **INSURED'S POLICY GROUP OR FECA NUMBER** R
Enter the Group Number from the subscriber's Blue Cross and Blue Shield Card.

11a. **DATE OF BIRTH AND SEX** O
Enter the six digit date, i.e., January 5, 1949 = 010549 (Place "X" in the appropriate box for insured's sex).

11b. **EMPLOYER'S NAME OR SCHOOL** O
Enter the subscriber's employer or school.

11c. **INSURANCE PLAN NAME OR PROGRAM NAME** O
Enter name of insurance plan, include name of state, i.e., Blue Shield of IL.

11d. **IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN** R
Place "X" in the appropriate box (If yes, then complete 9a-d).

12. **PATIENT OR AUTHORIZED PERSON'S SIGNATURE** O
Not required in filing Blue Shield Claims.

13. **INSURED OR AUTHORIZED PERSON'S SIGNATURE** O
Not required in filing Blue Shield Claims.

14. **DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY** R
Enter six digit date, i.e., February 11, 2001 = 021101.

15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE** R
Enter six digit date if applicable (i.e., November 3, 2001 = 110301).

16. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** O
Not required in filing Blue Shield Claims.

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** C
Enter name of referring physician if applicable. Use no special characters or punctuation.

17a. **I.D. NUMBER OF REFERRING PHYSICIAN** C
Enter the referring or ordering physician's Provider # or Physician's state licensure number in this field.

18. **HOSPITAL DATES RELATED TO CURRENT SERVICES** C
If services were related to hospitalization enter six digit dates of service, from and to dates i.e., from 032601 to 041601 (Required when Place of Service (POS) is 21, 31, 51, 52, 61).

19. **RESERVED FOR LOCAL USE** O
Leave blank when filing Blue Shield Claims.

20. **OUTSIDE LAB/CHARGES** O
If laboratory work was performed outside the physician's office, place "X" in "Yes" box and enter the total charges.

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** R
Enter the ICD-9-CM Codes. The primary diagnosis should be first, followed by other diagnoses. Enter up to 4 ICD-9-CM Codes.

22. **MEDICAID RESUBMISSION CODE** O
Not required in filing Blue Shield Claims.

23. **PRIOR AUTHORIZATION NUMBER** O
Not required in filing Blue Shield Claims.

24a. **DATE(S) OF SERVICE** R
Enter 6 digit dates of service, from and to dates (i.e., 032401 to 041401).

24b. **PLACE OF SERVICE** R
Enter the appropriate 2 digit POS Code (see the attached list).

24c. **TYPE OF SERVICE** R
Enter a one position alpha or numeric Type of Service (TOS) Code (see attached list).

24d. **PROCEDURES, SERVICES, OR SUPPLIES** R
Enter HCPCS or CPT procedure codes. Use modifiers to indicate unusual circumstances.
For anesthesia use the appropriate HCPCS or CPT surgery code, and Type of Service (TOS) = 7.

24e. **DIAGNOSIS CODE** R
Enter one ICD-9-CM diagnosis code for each procedure performed. Enter only one code per line of service.

24f. **CHARGES** R
Enter charge for each service. This should be original charge not the balance due or patient liability. Do not include any discounts.

24g. **DAYS OR UNITS** R
Enter the number of times this service was rendered.
Anesthesia units – do not enter number of units. Enter anesthesia time in minutes only (i.e. one hour and 26 minutes should be 86 minutes). When multiple services are provided enter actual number of services. Some procedure codes include several tests within their description. Submit one unit of service for these codes. For example: 95000 scratch test, up to 30 tests = 1 unit.

24h. **ESPDT** O
Not required in filing Blue Shield Claims.

24i. **EMG** O
Not required in filing Blue Shield Claims.

24j. **COB** O
Not required in filing Blue Shield Claims.

24k. **PERFORMING PROVIDER STATE LICENSE #** R
Enter performing provider State License Number without the dash example: 361234567

25. **FEDERAL TAX I.D. NUMBER** R
Enter your Federal Tax I.D. Number. Place "X" in the appropriate box for SSN or EIN.

26. **PATIENT ACCOUNT NUMBER** O
Enter any unique identification number you have assigned to the patient. If a patient number is entered in this field, it will be recorded on the explanation of payment voucher.

27. **ACCEPT ASSIGNMENT** R
Enter "X" in "Yes" box if provider should be paid. Enter in "X" in "No" box if patient should be paid.

28. **TOTAL CHARGE** R
Enter the total charges (total of all charges in 24f).

29. **AMOUNT PAID** C
Enter any amount paid by the patient only. Do not enter any amount paid by Medicare or other insurance.

30. **BALANCE DUE** C
Enter the difference, if any, between total charge and amount paid.

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS** R
The physician/supplier or his/her authorized representative must sign. the name, as well as the month, day and year the form was completed.

32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED** R
(if other than office or home) Show the name and address of the person, organization or facility performing the service. List the physician's practice address here, if different from item 33.

33. **PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE,** R
PHONE NUMBER, C
PIN# OR GROUP # R
Show name address, city, state and zip code of the physician or supplier who furnished the services.

(Phone number required if out of state provider).

BLUESHIELD PROVIDER NUMBER:
Enter your 8-digit Blue Shield Provider Number after the PIN #.
When filing as a group, enter your 8-digit Group Number after GRP#.

Place of Service Codes

CODES	DEFINITIONS
00-02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09-10	Unassigned
11	Office
12	Patient's Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16-19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	State of Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Unlisted Facility

Type of Service Codes

CODES	DEFINITIONS
1-	Medical Care
2-	Surgery
3-	Consultation
4-	Diagnostic X-Ray
5-	Diagnostic Laboratory
6-	Radiation Therapy
7-	Anesthesia
8-	Assistance at Surgery
9-	Other Medical Service
0-	Blood or Packed Red Cells
A-	Used DME
F-	Ambulatory Surgical Center
H-	Hospice
L-	Renal Supplies in the Home
M-	Alternate Payment for Maintenance Dialysis
N-	Kidney Donor
V-	Pneumococcal Vaccine
Y-	Second Opinion on Elective Surgery
Z-	Third Opinion on Elective Surgery

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, zip code, telephone number and provider number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in the BCBSIL's system just the way they leave your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

To obtain more information on electronic claim filing, call (312) 653-7954 or log on to www.bcbsil.com.