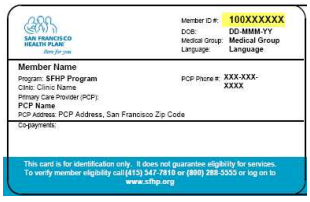
Instructions for Completing the CMS 1500 Claim Form

The Center of Medicaid and Medicare Services (CMS) form 1500 must be used to bill SFHP for medical services. The form is used by Physicians and Allied Health Professionals to submit claims for medical services. All items must be completed unless otherwise noted in these instructions. A CMS 1500 with field descriptions and instructions is included in the link below:

CMS 1500 Field Location	Required Field?	Description and Requirements
1	optional	Type of Insurance
1a	**Required**	Insured's **SFHP ID Number** – Enter the member's 11-digit SFHP number as it appears on the ID card. Do not use the SSN or CIN number when billing services. If you do not know the patient's SFHP ID, you can log onto our provider portal to look up the patient's ID. (Insert instructions/link) 
2	**Required**	Patient's Name – Enter the member's name as is indicated on the ID card. When submitting claims for a newborn infant using the mother's ID number, enter the infant's name in Box 2. Services rendered to an infant may be billed with the mother's ID for the month of birth and the month after only. Enter "Newborn using Mother's ID"/ "(twin a) or (twin b)" in the Reserved for Local Use field (Box 19).
3	**Required**	Patient's Birth date – Enter member's date of birth and check the box for male or female.
4	***If Applicable***	Insured's Name – Not required unless billing for an infant using the Mother's ID. See #2 above.
5	**Required**	Patient's Address – Enter member's complete address and telephone number.
6	***If Applicable***	Patient's Relationship to Insured – Only Self or Child are applicable.
7	not required	Insured's Address
8	not required	Patient Status

CMS 1500 Field Location	Required Field?	Description and Requirements
9a-d	not required	Other Insured's Information - Name, Policy/Group Number, Employer/School Name, Insurance Plan/Program Name
10a-c	not required	Patient's Condition Relation
10d	not required	Reserved For Local Use
11a-b	not required	Insured's Information - Name, Policy/Group Number, Employer/School Name, Insurance Plan/Program Name
11c	*If Applicable*	For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.
11d	**Required**	Is there another health benefit plan? Check Yes or No
12	not required	Signature and Date
13	not required	Insured's or Authorized Person's Signature
14	**Required**	Date of Current - Illness (First Symptom) OR Injury OR Pregnancy (LMP) - Enter the date of onset of the member's illness, the date of accident/injury or the date of the last menstrual period.
15	not required	If patient had same or similar illness give first date
16	not required	Dates Patient Unable to Work in Current Occupation
17	*If Applicable*	Name of Referring Provider or Other Source - Enter the full name of the Referring Provider. A referring/ordering provider is one who requests services for a member, such as provider consultation, diagnostic laboratory or radiological tests, physical or other therapies, pharmaceuticals or durable medical equipment.
17a	*If Applicable*	ID Number of Referring Physician - Enter State Medical License number.
17b	*If Applicable*	NPI - Enter Referring Provider's NPI number.
18	*If Applicable*	Hospitalization Dates Related to Current Services - Enter the date of hospital admission and discharge if the services billed are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.
19	*If Applicable*	Reserved for Local Use - Use this area for procedures that require additional information, justification or an Emergency Certification Statement. • This section may be used for an unlisted procedure code when explanation is required and clinical review is required. • If modifier "-99" multiple modifiers is entered in section 24d, they should be itemized in this section. All applicable modifiers for each line item should be listed. • Claims for "By Report" codes and complicated procedures should be detailed in this section if space

CMS 1500 Field Location	Required Field?	Description and Requirements
		permits. • All multiple procedures that could be mistaken for duplicate services performed should be detailed in this section. • Anesthesia start and stop times. • Itemization of miscellaneous supplies, etc.
20	*If Applicable*	Outside Lab? – Check "yes" when diagnostic test was performed by any entity other that the provider billing the service. If this claim includes charges for laboratory work performed by a licensed laboratory, enter and "X". "Outside Laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory.
21	**Required**	Diagnosis or Nature of Illness or Injury – Enter all letters and/or numbers of the ICD-9-CM code for each diagnosis, including fourth and fifth digits if present. The first diagnosis listed in section 21.1 indicates the primary reason for the service provided
22	not required	Medicaid Resubmission Code
23	*If Applicable*	Prior Authorization Number – Enter prior authorization or referral number.
Shaded Area Above Section 24	*If Applicable*	Use this area for and NDC/UPN information. These must be included, if applicable.
24A	**Required**	Dates of Service – Enter the date the service was rendered in the “from” and “to” boxes in the MMDDYY format. If services were provided on only one date, they will be indicated only in the “from” column. If the services were provided on multiple dates (i.e., DME rental, hemodialysis management, radiation therapy, etc), the range of dates and number of services should be indicated. “To” date should never be greater than the date the claim is received by the Health Plan.

CMS 1500 Field Location	Required Field?	Description and Requirements
24B	**Required**	Place of Service – Enter one code indicating where the service was rendered. 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 11 – Office Visit 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 25 – Birthing Center 26 – Military Treatment Facility 31 – Skilled Nursing Facility 32 – Nursing Facility 33 – Custodial Care Facility 34 – Hospice 41 – Ambulance – Land 42 – Ambulance – Air or Water 50 – Federally Qualified Health Center 51 – Inpatient Psychiatric Facility 52 – Psychiatric Facility Partial Hospitalization 53 – Community Mental Health Center 54 – Intermediate Care Facility 55 – Residential Substance Abuse Treatment Facility 56 – Psychiatric Residential Treatment Center 60 – Mass Immunization Center 61 – Comprehensive Inpatient Rehab Facility 62 – Comprehensive Outpatient Rehab Facility 65 – End Stage Renal Disease Treatment Facility 71 – State or Local Public Health Clinic7 2 – Rural Health Clinic 81 – Independent Laboratory 99 – Other Unlisted Facility
24C	*If Applicable*	Emergency Indicator – Check box and attach required documentation.

CMS 1500 Field Location	Required Field?	Description and Requirements
24D	**Required**	Procedures, Services or Supplies - Enter the applicable CPT and/or HCPCS National codes in this section. Modifiers, when applicable, are listed to the right of the primary code under the column marked "modifier". If the item is a medical supply, enter the two-digit manufacturer code in the modifier area after the five-digit medical supply code.
24E	**Required**	Diagnosis Pointer - Enter the diagnosis code number from box 21 that applies to the procedure code indicated in 24D.
24F	**Required**	Charges - Enter the charge for service in dollar amount format. If the item is a taxable medical supply, include the applicable state and county sales tax.
24G	**Required**	Days or Units - Enter the number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc. Do not enter a decimal point or leading zeroes. Do not leave blank as units should be at least 1.
24H	***If Applicable***	EPSDT Family Plan - Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related
24I	***If Applicable***	ID Qualifier - Enter "X" if billing for emergency services.
24J	***If Applicable***	Rendering Provider ID #/ NPI - Enter the Rendering Provider's NPI number
25	**Required**	Federal Tax ID Number - Enter the Federal Tax ID for the billing provider. (Note: if vendor tax ID # is shared between two or more individual vendors, the provider must submit claims using a SFHP-issued 3-digit suffix addition to the Tax ID number)
26	optional	Patient's Account Number -Enter the patient's medical record number or account number in this field. This number will be reflected on Explanation of Benefits (EOB) if populated.
27	not required	Accept Assignment?
28	**Required**	Total Charge -Enter the total for all services in dollar and cents. Do not include decimals. Do not leave blank.
29	***If Applicable***	Amount Paid - Enter the amount of payment received from the Other Health Coverage. Enter the full dollar amount and cents. Do not enter Medicare payments in this box. Do not enter decimals.
30	***If Applicable***	Balance Due - Enter the difference between the Total Charges and the Amount Paid in full dollar amount and cents. Do not enter decimals.
31	**Required**	Signature of Physician or Supplier Including Degrees or

CMS 1500 Field Location	Required Field?	Description and Requirements
		Credentials -The claims must be signed and dated by the provider or a representative assigned by the provider in black pen. An original signature is required. Stamps, initials or facsimiles are not acceptable.
32	**Required**	Service Facility Location Information - Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.
32a	**Required**	Service Facility Location Information - Enter the NPI of the facility where the services were rendered.
32b	***If Applicable***	Service Facility Location Information -Enter the Medi-Cal provider number for an atypical service facility.
33	**Required**	Billing Provider Info & Phone # (Pay-To) - Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number.
33a	**Required**	Billing Provider Info & Phone # (Pay-To, NPI) - Enter the billing provider's NPI.
33b	**Required**	Billing Provider Info & Phone # (Pay-To) - Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.