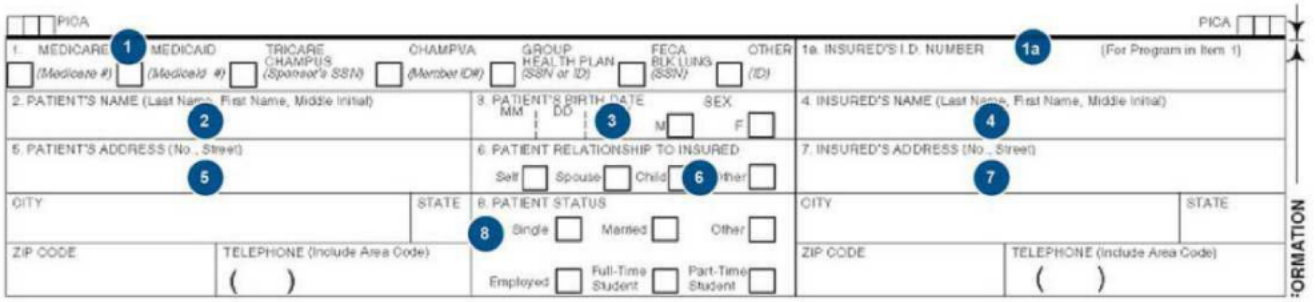
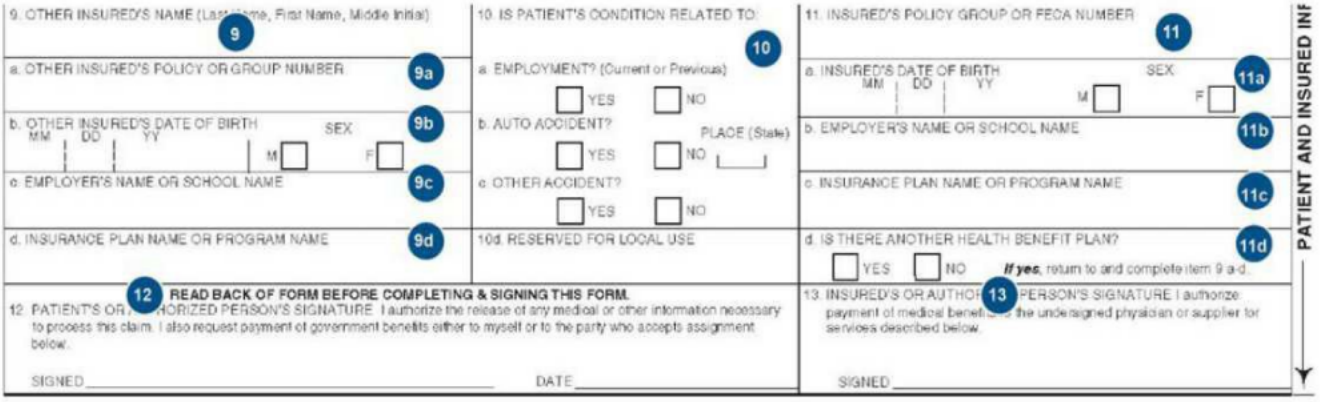
CMS 1500 (8/05) Claim Form Instructions

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
CMS 1500 Claim Form 			
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other.	Not Required
1a	**INSURED I.D. NUMBER**	The 10-digit Medicaid identification number on the member's CENPATICO BEHAVIORAL HEALTH I.D. card.	R
2	**PATIENT'S NAME (Last Name, First Name, Middle Initial)**	Enter the patient's name as it appears on the member's CENPATICO BEHAVIORAL HEALTH I.D. card. Do not use nicknames.	R
3	**PATIENT'S BIRTH DATE / SEX**	Enter the patient's 8-digit date of (MM|DD|YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = male F = female	R
4	**INSURED'S NAME**	Enter the patient's name as it appears on the member's CENPATICO BEHAVIORAL HEALTH I.D. card.	R

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
5	**PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)**	Enter the patient's complete address and telephone number including area code on the appropriate line. ➢ First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ➢ Second line – In the designated block, enter the city and state. ➢ Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	R
6	**PATIENT'S RELATION TO INSURED**	Always mark to indicate self.	C
7	**INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)**	Enter the patient's complete address and telephone number including area code on the appropriate line. ➢ First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ➢ Second line – In the designated block, enter the city and state. ➢ Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	**PATIENT STATUS**		Not Required

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
CMS 1500 Claim Form			
			
9	**OTHER INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)**	Refers to someone other than the patient. **REQUIRED** if patient is covered by another insurance plan. Enter the complete name of the insured. **NOTE:** COB claims that require attached EOBs must be submitted on paper.	C
9a	***OTHER INSURED'S POLICY OR GROUP NUMBER**	**REQUIRED** if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	**OTHER INSURED'S BIRTH DATE / SEX**	**REQUIRED** if # 9 is completed. Enter the 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate sex/gender. M = male F = female for the person listed in box 9.	C
9c	**EMPLOYER'S NAME OR SCHOOL NAME**	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	**INSURANCE PLAN NAME OR PROGRAM NAME**	**REQUIRED** if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	**IS PTIENT'S CONDITION RELATED TO:**	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	**RESERVED FOR LOCAL USE**		Not Required
11	**INSURED'S POLICY GROUP OR FECA NUMBER**	**REQUIRED** when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	**INSURED'S DATE OF BIRTH / SEX**	Same as field 3.	C
11b	**EMPLOYER'S NAME OR SCHOOL NAME**	**REQUIRED** if Employment is marked Yes in box 10a.	C
11c	**INSURANCE PLAN NAME OR PROGRAM NAME**	Enter name of the insurance Health Plan or program.	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
11d	**IS THERE ANOTHER HEALTH BENEFIT PLAN**	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**		Not Required.

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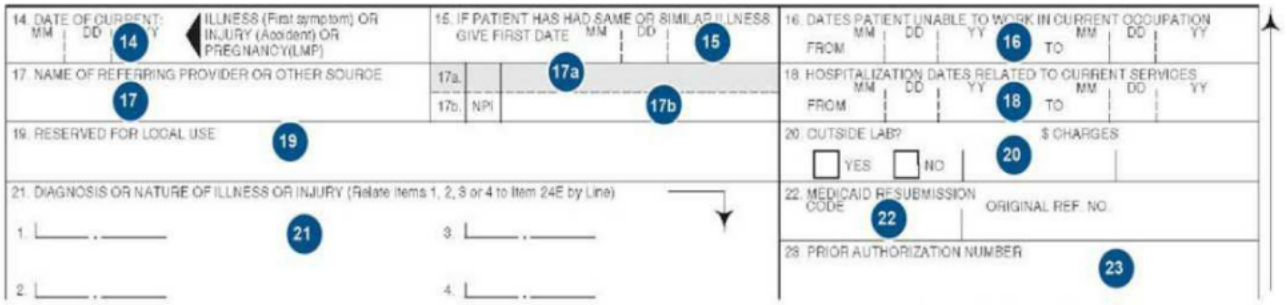
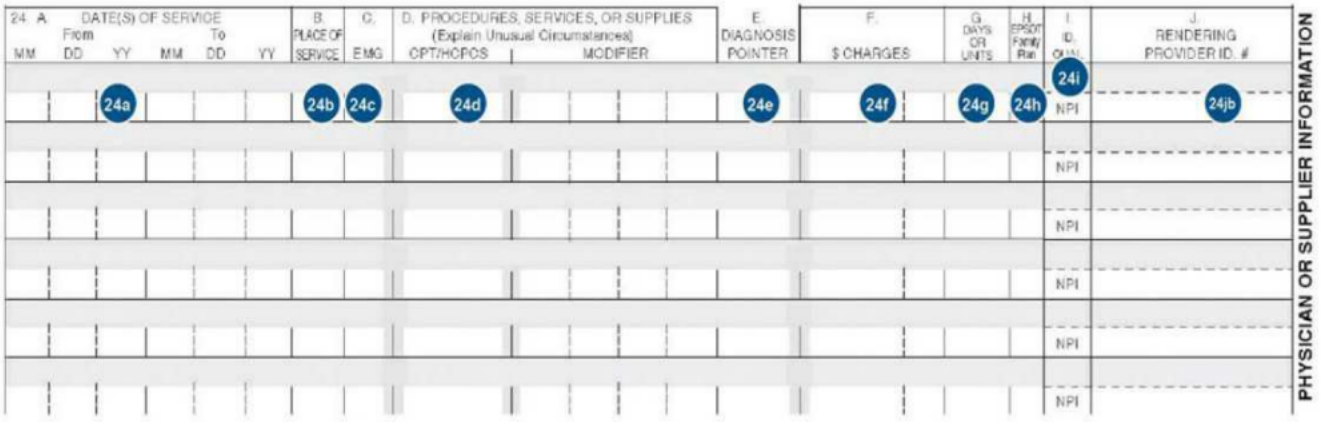


14	**DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)**	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date reflecting the first date of onset for the: ➢ Present illness ➢ Injury ➢ LMP (last menstrual period) if pregnant	C
15	**IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE**		Not Required
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**		Not Required
17	**NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	C
17a	**ID NUMBER OF REFERRING PHYSICIAN**	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	**NPI NUMBER OF REFERRING PHYSICIAN**	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**		Not Required
19	**RESERVED FOR LOCAL USE**		Not Required
20	**OUTSIDE LAB / CHARGES**		Not Required

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
21	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)**	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9-CM Volume 1 for the date of service. Diagnosis codes submitted must be a valid ICD-9 codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes are NOT acceptable as a primary diagnosis. **NOTE:** Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	**MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO.**	For re-submissions or adjustments, enter the 12-character DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "RESUBMISSION" to avoid denials for duplicate submission. **NOTE:** Re-submissions may **NOT** currently be submitted via EDI.	C
23	**PRIOR AUTHORIZATION NUMBER**	Enter the CENPATICO BEHAVIORAL HEALTH authorization or referral number. Refer to the CENPATICO BEHAVIORAL HEALTH Provider Manual for information on services requiring referral and/or prior authorization.	Not Required

CMS 1500 Claim Form



24A-J General Information	**Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24J. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.** ➢ **The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid Number qualifier, and Provider Medicaid Number.** ➢ **Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below and in Appendix 4 for information on how to complete.** ➢ **The un-shaded area of a claim line is for the entry of claim line item detail.**

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24A-G Shaded	**SUPPLEMENTAL INFORMATION**	The shaded top portion of each service claim line is used to report supplemental information for: ➢ NDC ➢ Anesthesia Start/Stop time & duration ➢ Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. ➢ HIBCC or GTIN number/code. For detailed instructions and qualifiers refer to Appendix 4 of this manual.	C
24A Un-shaded	**DATE(S) OF SERVICE**	Enter the date the service listed in 24D was performed (MM|DD|YY). If there is only one date enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed within a date span, enter the date span in the "From" and "To" fields. The count listed in field 24G for the service must correspond with the date span entered.	R
24B Un-shaded	**PLACE OF SERVICE**	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link: http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/placeofservice.pdf	R
24C Un-shaded	**EMG**	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	R

<table>
<tr><th>FIELD#</th><th>FIELD DESCRIPTION</th><th>INSTRUCTION OR COMMENTS</th><th>REQUIRED OR CONDITIONAL</th></tr>
<tr><td>24D
Un-shaded</td><td>PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER</td><td>Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.

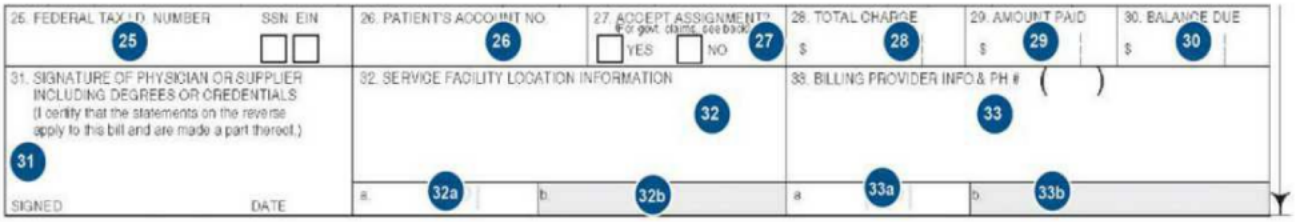
Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.

The following national modifiers are recognized as modifiers that will impact the pricing of your claim.

<table>
<tr><td>24</td><td>26</td><td>50</td><td>51</td><td>52</td></tr>
<tr><td>53</td><td>54</td><td>55</td><td>62</td><td>66</td></tr>
<tr><td>76</td><td>78</td><td>79</td><td>80</td><td>81</td></tr>
<tr><td>82</td><td>99</td><td>AA</td><td>AD</td><td>FP</td></tr>
<tr><td>LL</td><td>LT</td><td>NU</td><td>QK</td><td>QS</td></tr>
<tr><td>QX</td><td>QY</td><td>QZ</td><td>RR</td><td>RT</td></tr>
<tr><td>SB</td><td>TC</td><td>UE</td><td></td><td></td></tr>
</table>
</td><td>R</td></tr>
<tr><td>24E
Un-shaded</td><td>DIAGNOSIS CODE</td><td>Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9 codes for the date of service or the claim will be rejected/denied.</td><td>R</td></tr>
<tr><td>24F
Un-shaded</td><td>CHARGES</td><td>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td><td>R</td></tr>
<tr><td>24G
Un-shaded</td><td>DAYS OR UNITS</td><td>Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.</td><td>R</td></tr>
<tr><td>24H
Shaded</td><td>EPSDT (CHCUP) Family Planning</td><td>Leave Blank</td><td>Not Required</td></tr>
<tr><td>24H
Un-shaded</td><td>EPSDT (CHCUP) Family Planning</td><td>Enter the appropriate qualifier for EPSDT visit</td><td>C</td></tr>
<tr><td>24I
Shaded</td><td>ID QUALIFIER</td><td>Use ZZ qualifier for Taxonomy</td><td>C</td></tr>
</table>

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
24Ja Shaded	**Non-NPI PROVIDER ID#**	**Enter as designated below the Medicaid ID number or taxonomy code.** ➢ *Typical Providers*: Enter the Provider taxonomy code or Medicaid Provider ID number that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. ➢ *Atypical Providers*: Enter the 6-digit Medicaid Provider ID number.	R
24Jb Un-shaded	**NPI PROVIDER ID**	**Typical Providers ONLY:** Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered.	R

CMS 1500 Claim Form



25	**FEDERAL TAX I.D. NUMBER SSN/EIN**	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	**PATIENT'S ACCOUNT NO.**	Enter the provider's billing account number.	Not Required
27	**ACCEPT ASSIGNMENT?**	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	R
28	**TOTAL CHARGES**	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
29	**AMOUNT PAID**	**REQUIRED** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing CENPATICO BEHAVIORAL HEALTH . Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	**BALANCE DUE**	**REQUIRED** when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature. Note: does not exist in the electronic 837P.	Required
32	**SERVICE FACILITY LOCATION INFORMATION**	**REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** Enter the name and physical location. (P.O. Box #'s are **not** acceptable here**.)** ➢ First line – Enter the business/facility/practice name. ➢ Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ➢ Third line – In the designated block, enter the city and state. ➢ Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen.	C

FIELD#	FIELD DESCRIPTION	INSTRUCTION OR COMMENTS	REQUIRED OR CONDITIONAL
32a	**NPI – SERVICES RENDERED**	**Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	**OTHER PROVIDER ID**	**REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** ➢ *Typical Providers* Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). ➢ *Atypical Providers* Enter the 2-character qualifier 1D followed by the 6-character Medicaid Provider ID number (no spaces).	C
33	**BILLING PROVIDER INFO & PH #**	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. ➢ First line – Enter the business/facility/practice name. ➢ Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). ➢ Third line – In the designated block, enter the city and state. ➢ Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).	R
33a	**GROUP BILLING NPI**	**Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** Enter the 10-character NPI ID.	R
33b	**GROUP BILLING OTHER ID**	**Enter as designated below the Billing Group Medicaid ID number or taxonomy code.** ➢ *Typical Providers*: Enter the Provider taxonomy code. Use ZZ qualifier. ➢ *Atypical Providers*: Enter the 6-digit Medicaid Provider ID number.	R

NOTE: Required fields denoted by an **R** Conditional fields denoted by a **C**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY | STATE

8. PATIENT STATUS Single Married Other

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)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 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.

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.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. **R**

2. **C**

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1		*R*	*R*	***R***		**R**	*****R*****	*R*	C	*R* NPI	******R******
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO *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. SERVICE FACILITY LOCATION INFORMATION

**********C**********

a. *****C***** *** b. ******C*********

33. BILLING PROVIDER INFO & PH # ( )

**********R**********

a. *****R***** b.