

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ( )		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. EMPLOYER'S NAME OR SCHOOL NAME		b. INSURANCE PLAN NAME OR PROGRAM NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> 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 _____	
---	--	---	--

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 FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		17b. NPI _____		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
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 gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
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.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____		33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____							

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

**Item 1. MEDICARE:**

Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not applicable.

**Item 1a. INSURED'S I.D. NUMBER:**

Enter the patient's Medicare Health Insurance Claim Number (HICN), whether Medicare is primary or secondary payer.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Loop 2010BA, NM1/IL, 09

**Item 2. PATIENT'S NAME:**

Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient's Last Name: Loop 2010BA, NM1/IL, 03
- Patient's First Name: Loop 2010BA, NM1/IL, 04

**Item 3. PATIENT'S BIRTH DATE:**

Enter the patient's 8-digit birth date (MM/DD/CCYY) and sex.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient's Birth Date: Loop 2010BA, DMG, 02
- Patient's Sex: Loop 2010BA, DMG, 03

**Item 4. INSURED'S NAME:**

If there is insurance primary to Medicare, either through the patient or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Insured Last Name: Loop 2330A, NM1/IL, 03
- Insured First Name: Loop 2330A, NM1/IL, 04

**Item 5. PATIENT'S ADDRESS:**

Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient Address Line 1: Loop 2010BA, N3, 01
- Patient City: Loop 2010BA, N4, 01
- Patient State: Loop 2010BA, N4, 02
- Patient Zip Code: Loop 2010BA, N4, 03

**Item 6. PATIENT'S RELATIONSHIP TO INSURED:**

Check the appropriate box to indicate the patient's relationship to the insured when Item 4 is completed.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient Relationship to Insured: Loop 2000B, SBR, 02



**Item 7. INSURED'S ADDRESS:**

Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this Item only when Items 4, 6 and 11 are completed.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Insured's Address and Phone Number: Not Used – Use only if Insured is Different than Patient

**Item 8. PATIENT STATUS:**

Check the appropriate box for the patient's marital status and whether employed or a student.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient Status: Not used.
- Patient Student Status: Not used.
- Patient Employment Status: Not used.

**Item 9. OTHER INSURED'S NAME:**

Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in Item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank.

Note: Only participating physicians and suppliers are to complete Item 9 and its subdivisions, and only when the patient wishes to assign his/her benefits under a Medigap policy to the participating physician or supplier.

Participating physicians and suppliers must enter information required in Item 9 and its subdivision if requested by the patient. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a patient elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See Pub. 100-04, Chapter 28 of the Internet Only Manual [IOM].)

Medigap: A Medigap policy meets the statutory definition of a 'Medicare supplemental policy' contained in Section 1882 (g) (1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation, which is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the 'gaps' in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as 'specified disease' or 'hospital indemnity' coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in Item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Other Insured Last Name: Loop 2330A, NM1/IL, 03
- Other Insured First Name: Loop 2330A, NM1/IL, 04
- Other Insured Middle Initial: Loop 2330A, NM1/IL, 05

**Item 9a. OTHER INSURED'S POLICY OR GROUP NUMBER:**

Enter the policy and/or group number of the Medigap enrollee preceded by **MEDIGAP, MG, or MGAP.**

**NOTE:** Item 9d must be completed if you enter a policy and/or group number in Item 9a.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Other Insurance Policy or Group #: Loop 2330A, NM1/IL, 09

**Item 9b. OTHER INSURED'S DATE OF BIRTH:**

Enter the Medigap insured's 8-digit birth date (MM/DD/CCYY) and sex.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Other Insurance Date of Birth: Loop 2320, DMG, 02

**Item 9c. EMPLOYER'S NAME OR SCHOOL NAME:**

Disregard the "Employer's Name or School Name" which is printed on the form. Enter the claims processing address or the Medigap insurer. Use the abbreviated street address, two letter State postal code, and zip code copied from the Medigap enrollee's Medigap identification card. For example:

1257 Anywhere Street  
Baltimore, Maryland 21204

*is shown as "1257 Anywhere St. Baltimore, MD 21204"*

**Note:** If a carrier assigned unique physician identifier of a Medigap insurer appears in Item 9d, Item 9c may be left blank.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Employer Name or School Name: Loop 2330B, NM1/PR, 03

**Item 9d. INSURANCE PLAN NAME OR PROGRAM NAME:**

Enter the name of the Medigap enrollee's insurance company or the Medigap insurer's unique identifier provided by the local Medicare carrier.

If you are a participating physician or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in Item 9, 9a, 9b, 9c, and 9d must be complete and accurate. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Insurance Plan Name or Program Name (Medigap 5-digit Insurer Code): Loop 2330B, NM1/PR, 09

**Items 10a-c. IS THE PATIENT'S CONDITION RELATED TO:**

Check 'YES' or 'NO' to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24. Enter the State postal code. Any items checked 'YES,' indicates there may be other insurance primary to Medicare. Identify primary insurance information in Item 11.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Is Patient's Condition Related To: Employment, Auto Accident, Other Accident: Loop 2300, CLM, 11



**Item 10d. RESERVED FOR LOCAL USE:**

Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

*Currently, Palmetto GBA receives an eligibility tape from Medicaid. This procedure will continue and this will not be a required item at this time.*

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not applicable.

**Item 11. INSURED'S POLICY GROUP OR FECA NUMBER:**

**This item must be completed. By completing this item, the physician/supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer.**

***Important: This item must NOT be left blank or the claim will be rejected.***

- If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11a-11c. Items 4, 6 and 7 must also be completed.
- Note: Enter the appropriate information in Item 11c if insurance primary to Medicare is indicated in Item 11.
- If there is NO insurance primary to Medicare, enter the word 'NONE' and proceed to Item 12.
- If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word 'NONE' and proceed to Item 11b.
- If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word 'None' in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.
- Insurance primary to Medicare: Circumstances under which Medicare payment may be secondary to other insurance include:
  - Group Health Plan coverage:
    - Working Aged
    - Disability (large group health plan)
    - End stage renal disease
  - No fault and/or other liability
  - Work-related illness/injury
    - Workers' Compensation
    - Black Lung
    - Veterans Benefits

**NOTE:** For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Chapter 3, *Medicare Secondary Payer Manual*.)

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Insured Group or Policy Number: Loop 2320, SBR, 03
- Claim Filing Indicator: Loop 2320, SBR, 09
- Insurance Type Code: Loop 2320, SBR, 05

**Item 11a. INSURED'S DATE OF BIRTH:**

Enter the insured's 8-digit birth date (MM/DD/CCYY) and sex if different from Item 3.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Insured Date of Birth: Loop 2320, DMG, 02

**Item 11b. EMPLOYER'S NAME OR SCHOOL NAME:**

Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) retirement date preceded by the word 'RETIRED.'

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Employer Name or School Name: Loop 2330B, NM1/PR, 03

**Item 11c. INSURANCE PLAN NAME OR PROGRAM NAME:**

Enter the 9-digit PAYERID number for the primary insurer. If no PAYERID exists, then complete insurance primary payer's program or plan name (e.g., Blue Shield of (State)). If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in Item 11.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Other Insured Group Name: Loop 2320, SBR, 04

**Item 11d. IS THERE ANOTHER HEALTH BENEFIT PLAN?**

Leave blank. Not required by Medicare.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- **Is there another Health Benefit Plan?: When Medicare is the Secondary Payer or the patient has a Medigap Policy, Loop 2320 and 2330 MUST be provided. The presence of these loops indicates the patient has another Health Benefit Plan.**

**Item 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:**

The patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alphanumeric date (e.g., January 1, 2007) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, 'General Billing Requirements.' If the patient is physically or mentally unable to sign, a representative as specified in Pub. 100-4, Chapter 1, 'General Billing Requirements,' may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by 'by' the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment of the claim.

**Signature by mark (X):** When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient Signature Source Code: Loop 2300, CLM, 10
- Release of Information Indicator: Loop 2300, CLM, 09

**Item 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:**

The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in Item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider or service or supplier's office must be insurer specific. It may state that the authorization applies to all services until it is revoked.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not applicable.



**Item 14. DATE OF CURRENT:**

Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the X-ray to document subluxation in Item 19.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Accident Date: Loop 2300, DTP/439, 03
- Initial Treatment Date: Loop 2300 or 2400, DTP/454, 03

**Item 15. IF THE PATIENT HAS HAD SAME OR SIMILAR SERVICES ILLNESS GIVE FIRST DATE:**

Leave blank. Not required by Medicare.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Same/Similar Symptom Indicator: Not Used
- Onset of Similar Symptoms or Illness: Loop 2300 or 2400, DTP/438, 03

**Item 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:**

If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Dates patient was unable to work in current occupation: Not used for Medicare

**Item 17. NAME OR REFERRING PHYSICIAN OR OTHER SOURCE:**

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

The term 'physician' when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;
4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or
5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

**Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

**Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Onset of Current Illness or Injury: Loop 2300 or 2400, DTP/438, 03
- Referring Provider Last Name: Loop 2310A or 2420F, NM1/DN, 03
- Referring Provider First Name: Loop 2310A or 2420F, NM1/DN, 04
- Ordering Provider Last Name: Loop 2420E, NM1/DK, 03
- Ordering Provider First Name: Loop 2420E, NM1/DK, 04

**Item 17a. I.D. NUMBER OF REFERRING PHYSICIAN:**

Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17. The UPIN may be reported on the Form CMS-1500, and MUST be reported if an NPI is not available.

**NOTE:** Field 17a and/or 17b is required when a service was ordered or referred by a physician.

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Ordering Provider Secondary Identifier (UPIN): Loop 2420E, REF/1G, 02
- Referring Provider Secondary Identifier (UPIN): Loop 2310A or 2420F, REF/1G, 02

**Item 17b. NPI Number of Referring Physician:**

Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available.

**NOTE:** Field 17a and/or 17b is required when a service was ordered or referred by a physician.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Ordering Provider National Provider Identifier (NPI): Loop 2420E, NM1/DK, 09
- Referring Provider National Provider Identifier (NPI): Loop 2310A or 2420F, NM1/DN, 09

**Item 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:**

Enter either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not applicable.

**Item 19. RESERVED FOR LOCAL USE:**

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24K of this section.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an 'unlisted procedure code' or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when CPT modifier -99 (multiple modifiers) is entered in item 24d. If CPT modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 CPT modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and 'mod' represents all modifiers applicable to the referenced line item.

***CPT modifier 99 is only appropriate when more than four modifiers are necessary per line item. When only four modifiers apply, enter each modifier in the existing space in Item 24D.***

Enter the statement 'Homebound' when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, 'Covered Medical and Other Health Services,' and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, 'Laboratory Services From Independent Labs, Physicians and Providers,' and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, 'Definitions,' respectively for the definition of 'homebound' and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, 'Patient refuses to assign benefits' when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, 'Testing for hearing aid' when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed. ***Note: A dental exam is covered for limited services when it is part of a comprehensive evaluation and management service.***

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care. ***Note: The physician billing CPT modifier 54 will indicate the relinquished date of care and responsibility. The provider billing CPT modifier 55 will indicate the date the post-operative care and responsibility is assumed.***

Enter demonstration ID number '30' for all national emphysema treatment trial claims.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)

***Unless indicated on the previous pages, no other documentation is to be entered in Item 19 of the CMS-1500 claim form. Only the information, as listed on the previous pages, will be accepted in Item 19. Claims will be rejected if above instructions are not followed.***



**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Ordering Provider Primary Identifier (SSN or EIN): Loop 2420E, NM1/DK, 09
- Referring Provider Primary Identifier (SSN or EIN): Loop 2310A or 2420F, NM1/DN, 09
- Referring Provider Secondary Identifier (UPIN): Loop 2310A or 2420F, REF/1G, 02
- Narrative: Loop 2300 or 2400, NTE, 02
- Date Last Seen and X-ray: Loop 2300 or 2400, DTP/304, 03
- Supervising UPIN: Loop 2310E or 2420D, REF/1G, 02
- Anesthesia Minutes: Loop 2400, SV1, 04 (03=MJ)
- Homebound Indicator: Loop 2300, CRC/75, 03
- Hospice Employed Provider Indicator: Loop 2400, CRC/70, 02
- Assumed & Relinquished Care Dates: Loop 2300, DTP/90 or 91, 03

**Item 20. OUTSIDE LAB — CHARGES:**

Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the 'YES' block is checked. A 'YES' check indicates that an entity other than the entity billing for the services performed the diagnostic test. A 'NO' check indicates, 'no purchased tests are included on the claim.' When 'YES' is annotated, Item 32 must be completed.

When billing for multiple purchased diagnostic tests, each test must be submitted on a separate CMS-1500 claim form.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Purchased Service Charges: Loop 2400, PS1, 02

**Item 21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY:**

Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to eight diagnosis codes. Providers and suppliers must place two diagnosis codes in each of the fields 1-4 in item 21 of the CMS-1500 claim form when more than four diagnosis codes are submitted. These two diagnosis codes must be separated by a space, comma, dash, etc. in order for us to validate the diagnosis(s) being submitted.

If the diagnoses are not submitted as indicated, there will be a possibility that the diagnoses will not be processed correctly or accepted.

All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Only ICD-9-CM code numbers should be listed in Item 21. Narrative descriptions/diagnoses could cause the claim to deny.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Diagnosis 1: Loop 2300, HI, 01-2
- Diagnosis 2: Loop 2300, HI, 02-2
- Diagnosis 3: Loop 2300, HI, 03-2
- Diagnosis 4: Loop 2300, HI, 04-2

**Item 22. MEDICAID RESUBMISSION CODE:**

Leave blank. Not required by Medicare.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not applicable.

**Item 23. PRIOR AUTHORIZATION NUMBER:**

- Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.
- Enter the 7-digit Investigational Device Exemption (IDE) number when an investigational device is used in a FDA-approved clinical trial.
- For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI when effective) of the home health agency (HHA) or hospice when HCPCS code G0181 (HH) or G0182 (Hospice) is billed.
- Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.
- Ambulance providers must enter the five-digit zip code for the point of pickup.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- CLIA Number: Loop 2300 or 2400, REF/X4, 02
- Prior Authorization Number: Loop 2300 or 2400, REF/G1, 02
- Hospice (Home Health Agency or Care Plan Oversight Numbers): Loop 2310D, REF/LU, 02 (NM101=FA)

**Item 24a. DATE(s) OF SERVICE:**

The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. At this time, the shaded area in 24a through 24h is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When 'from' and 'to' dates are shown for a series of identical services, enter the number of days or units in column 24G.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Dates of Service (From Dates): Loop 2400, DTP/472, 03
- Dates of Service (To Dates): Loop 2400, DTP/472, 03

**Item 24b. PLACE OF SERVICE:**

Enter the appropriate place of service code(s) from the list provided in Pub. 100-4, Chapter 26, Section 10.5. Identify the location, using a place of service code, for each item used or service performed.

**NOTE:** When a service is rendered to a hospital inpatient, use the 'inpatient hospital' code.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Place of Service: Loop 2300, CLM, 05 or Loop 2400, SV1, 05

**Item 24c. TYPE OF SERVICE:**

Medicare providers are not required to complete this item.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not applicable.



**Item 24d. PROCEDURES, SERVICES, OR SUPPLIES:**

- Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.
- Enter the specific procedure code without a narrative description. However, when reporting an 'unlisted procedure code' or a 'not otherwise classified' (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Procedure Code: Loop 2400, SV1, 01-2

**Item 24e. DIAGNOSIS CODE:**

- Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service. Enter 1, 2, 3, 4, 5, 6, 7 or 8.
- If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Diagnosis Pointer: Loop 2400, SV1, 07-1

**Item 24f. CHARGES:**

Enter the charge for each listed service.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Charges: Loop 2400, SV1, 02

**Item 24g. DAYS OR UNITS:**

- Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.
- Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.
- For anesthesia, show the elapsed time (minutes) in Item 24g. Convert hours into minutes, and enter the total minutes required for this procedure.
- For instructions on submitting units for oxygen claims, see the Medicare Claims Processing Manual, Pub. 100-4, Chapter 20, section 130.6.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Days or Units of Service: Loop 2400, SV1, 04 (03=UN)
- Anesthesia Minutes: Loop 2400, SV1, 04 (03=MJ)

**Item 24h. EPSDT FAMILY PLAN:**

Leave blank. Not required by Medicare.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Not Applicable.

**Item 24i. LEGACY QUALIFIER RENDERING PROVIDER:**

Enter the ID qualifier 1 C in the shaded portion.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Legacy Qualifier Rendering Provider: Loop 2310B or 2420A, REF/IC, 01
- Enter the ID qualifier 1 C in the shaded portion.

**Item 24j. LEGACY PROVIDER NUMBER (PTAN)/NPI RENDERING PROVIDER:**

- Enter the rendering provider's PIN (PTAN) in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.
- Enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Rendering provider Legacy Number (shaded area): Loop 2310B or 2420A, REF/1C, 02
- NPI of rendering provider (unshaded area): Loop 2310B or 2420A, NM1/82, 09 (08=XX)

**Item 25. FEDERAL TAX I.D. NUMBER:**

Enter your provider of service or supplier Federal Tax I.D. (Employer Identification Number) or Social Security Number.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Provider SSN# or EIN#: Loop 2010AA or 2010AB, NM1/85 or 87, 09 (NM108 = 24 or 34)



**Item 26. PATIENT'S ACCOUNT NUMBER:**

Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist you in patient identification.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Patient's Account Number: Loop 2300, CLM, 01

**Item 27. ACCEPT ASSIGNMENT:**

Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Accept Assignment: Loop 2300, CLM, 07

**Item 28. TOTAL CHARGES:**

Enter total charges for the services (i.e., total of all charges in Item 24f).

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Total Charges: Loop 2300, CLM, 02

**Item 29. AMOUNT PAID:**

Enter the total amount the patient paid on the covered services only.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Amount Paid: Loop 2300, AMT/F5, 02

**Item 30. BALANCE DUE:**

Leave blank. Not required by Medicare.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Balance Due: Not Used.

**Item 31. SIGNATURE OF PHYSICIAN OR SUPPLIER:**

Enter the signature of the provider of service or supplier, or his/her representative, and either the 6-digit date (MM/DD/YY or 8-digit (MM/DD/CCYY), or alphanumeric date (January 1, 2007) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Provider Signature Indicator: Loop 2300, CLM, 06

**Item 32. NAME AND COMPLETE ADDRESS OF FACILITY (INCLUDING ZIP CODE) WHERE SERVICES WERE RENDERED:**

Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, *enter* the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

**NOTE:** A PO Box is not an acceptable address.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Facility Lab Name: Loop 2310D, NM1/FA, 03
- Facility Lab PIN: Loop 2310D, REF/LU, 02
- Place of Service Address: Loop 2310D, N3, 01
- Place of Service City: Loop 2310D, N4, 01
- Place of Service State: Loop 2310D, N4, 02
- Place of Service Zip Code: Loop 2310D, N4, 03
- Lab ID: Loop 2400, PS1, 01
- Mammography Certification Number: Loop 2300 or 2400, REF/EW, 02

**Item 32a. FACILITY NPI NUMBER:**

- Enter the NPI of the service facility.
- Providers of service (namely physicians) shall identify the supplier's NPI when billing for purchased diagnostic tests.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Facility NPI Number: Loop 2310D, NM1/FA, 09



**Item 32b. FACILITY QUALIFIER & LEGACY NUMBER:**

- Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility.
- Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Facility Qualifier and Legacy Number: Loop 2310D, REF/LU, 02

**Item 33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:**

Enter the provider of service or supplier's billing name, address, zip code, and telephone number.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Organization Name: Loop 2010AA or 2010AB, NM1/85 or 87, 03
- Provider's Last Name: Loop 2010AA or 2010AB, NM1/85 or 87, 03
- Provider's First Name: Loop 2010AA or 2010AB, NM1/85 or 87, 04
- Address: Loop 2010AA or 2010AB, N3, 01
- City: Loop 2010AA or 2010AB, N4, 01
- State: Loop 2010AA or 2010AB, N4, 02
- Zip Code: Loop 2010AA or 2010AB, N4, 03
- Provider Identification Number (Group or Individual PIN): Loop 2010AA or 2010AB, REF/1C, 02

**Item 33a. BILLING PROVIDER NPI NUMBER:**

Enter the NPI of the billing provider or group.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Billing Provider NPI: 2010AA/NM1/85/09, (08 = XX)

**Item 33b. BILLING PROVIDER QUALIFIER & LEGACY NUMBER:**

Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group.

**HIPAA ANSI 4010A1 Loop, Segment, Element:**

- Billing Provider Legacy Number of PIN: 2010AA/REF/1C/02