PARTNERSHIP HEALTHPLAN OF CALIFORNIA
HEALTHY FAMILIES
CLAIMS DEPARTMENT

II.A. CMS 1500 Billing Form

The information listed below will point out the CMS 1500 fields that must be completed accurately and completely in order to avoid claim suspense or denial. A copy of a CMS 1500 form follows.

ITEM	Description
1	**Medicaid/Medicare/Other ID**. Enter 'X' in Group Healthplan (SSN or ID)
1a	**Insured's ID Number.** Enter the member's identification number as it appears on the PHC Healthy Families Identification card.
2	**Patient's Name.** Last Name, First Name, and Middle Initial.
3	**Patient's Birth Date/Sex.** Enter the member's date of birth in the six-digit MMDDYY format.
4	**Insured's Name.**
5	**Patient's Address/Telephone.** Enter the member's complete name and address and phone number.
6	**Patient's Relationship to Insured.** Self
7	**Insured's Address.** N/A
8	**Patient Status.** Complete appropriate box.
9	**Other Insured's Name.** Complete if applicable.
9a	**Other Insured's Policy or Group Number.** Complete if applicable.
9b	**Other Insured's Date of Birth.** Complete if applicable.
9c	**Employer's Name or School Name.** Complete if applicable
9d	**Insurance Plan Name or Program Name.** Complete if applicable.

ITEM	Description
10	**Is Patient's Condition Related To:**
10a	**Employment?** Enter an "X" in the *YES* box *if* accident/injury is employment related. If YES is checked, the date of the accident must be entered in (Box 14) *Date of Current Illness*, *injury or Pregnancy*. Put an "X" in the *NO* box *if* accident/injury is not employment related.
10b	**Auto Accident?** Enter an "X" in the *YES* Box *if* accident/injury is Auto Related. If YES is checked, the date of the accident must be entered in (Box 14) *Date of Current Illness, injury or Pregnancy.* Put an "X" in the *NO* box *if* accident/injury is not Auto related.
10c	**Other Accident?** Enter an "X" in the *YES* box *if* related to an accident/injury. If YES is checked, the date of the accident must be entered in (Box 14) *Date of Current Illness, injury or Pregnancy.* Put an "X" in the *NO* box *if* it is not related to an accident/injury.
10d	**Reserved for Local Use (Co-Pay).** If applicable, enter the amount of the member's co-pay for the procedure, service or supply. Enter with decimal points.
11	**Insured's Policy Group or FECA Number.** Complete if 11d applies.
11a	**Insured's Date of Birth/Sex.** Complete if 11d applies.
11b	**Employer's Name or School Name.** Complete if 11d applies.
11c	**Insurance Plan Name or Program Name.** Complete if 11d applies.
11d	**Is There Another Health Benefit Plan?** If the Other Health Coverage has paid, enter the amount in the right side of this field. Note: Be sure 11a, 11b, and 11c are filled out correctly when the paid amount is entered in the field. Note: Be sure to attach the Other Carrier(s)/Medicare's EOMB, EOB, RA, showing their payment/denial. Make sure that the pay/deny explanation is included.
12	**Patient's or Authorized Person's Signature.** N/A
13	**Insured's or Authorized Person's Signature.** N/A
14	**Date of Current Illness, Injury or Pregnancy (LMP).** If applicable, enter the date of onset of the member's illness, the date of the accident/injury, or the date of the last menstrual period (LMP).

ITEM	Description
15	**If Patient Has Had Same or Similar Illness. Give First Date.** N/A
16	**Dates Patient Unable to Work in Current Occupation.** N/A
17	**Name of Referring Physician or Other Source.** Enter the name of the referring Physician in Box 17 and the referring Physicians ID number in Box 17a. If the referring provider is a non-physician medical practitioner working under the supervision of a physician, the name of the non-physician medical practitioner must be entered in Box 17.
17a	**ID Number of Referring Physician.**
18	**Hospitalization Dates Related to Current Services.** Enter the dates of hospital admission and discharge if the services are related to a hospitalization. If the patient has not been discharged, leave the discharge date blank.
19	**Reserved For Local Use.** Use this area for procedures that require additional information, justification, or an Emergency Certification Statement.
20	**Outside Lab.** N/A **Outside Lab Charges.** N/A
21.1	**Diagnosis or Nature of Illness or Injury.** Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis including fourth and fifth digits if present (do not enter decimal point).
21.2-21.4	**Diagnosis or Nature of Illness or Injury.** If applicable, enter all letters and/or numbers of the ICD-9-CM code for any additional diagnosis including fourth and fifth digits if present (do not enter decimal point).
22	**Medicaid Resubmission Code/Original Ref. No.** N/A
23	**Prior Authorization Number.** For services requiring a PHC Healthy Families Treatment Authorization Request (TAR) or Referral authorization (RAF), enter the PHC Healthy Families TAR/RAF Number. Services billed must match the services approved on the TAR/RAF. **Note:** You may attach a copy of the PHC Healthy Families TAR/RAF with your claim form.
24.1	**Claim Line**

ITEM	Description

24A **Date(s) of Service.** Enter the date the service was rendered in the "From" and "To" boxes in the six-digit, MMDDYY (month, Day, and Year) format. "From-Through" billing may be used for both consecutive and non-consecutive days of service when billing for the following services: Dialysis, Global Obstetrical Services, Radiation Therapy, and Ambulance Services.

24B **Place of Service.** Enter one code from the list below, indicating where the service was rendered.

Code	Place of Service
11	Office
12	Home
21	Inpatient
22	Outpatient
23	Emergency Room (hospital)
24	Ambulatory Surgery Clinic
25	Birthing Center
31	Skilled Nursing Facility (SNF)
32	Nursing Facility (NF)
41	Ambulance (Land)
42	Ambulance (Air or Water)
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
55	Residential Substance Abuse Treatment Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other (if subacute care, use modifier –HB to indicate adult or modifier –HA to indicate child)

24C **Type of Service.** N/A

24D **Procedures, Services or Supplies/Modifier.** Enter the applicable procedure code (HCPCS, CPT-4, or NDC) and modifier. PHC accepts up to four modifiers for a procedure on a single claim line. Enter modifiers directly after the procedure code without any spaces.

Modifiers: For a listing of required and approved PHC Healthy Families modifier codes, refer to the PHC Healthy Families Provider Manual.

24E **Diagnosis Code.** Enter the diagnosis listed in Box 21 which applies to the service line.

ITEM	Description
24F	**Charges.** Enter the usual and customary fee for service(s). Do not enter decimal point(.) or dollar sign ($). Enter the full dollar amount and cents even if the amount is even (e.g. If billing for $100, enter 10000 not 100.) If an item is a taxable medical supply include the applicable state and county sales tax.
24G	**Days or Units.** Enter the number of medical visits or procedures, surgical lesions, hours of detention time, units of anesthesia time, items or units of service, etc. Size of field is 999. Do not enter decimal point (.). Providers billing for units of time should enter the time in 15-minute increments (e.g. For one hour, enter "4").
24H	**Family Planning.** Enter code "1" or "2" if the services rendered are related to family planning (FP). Leave blank if not FP.
24I	**EMG.** Leave this blank unless billing for emergency services. Enter an "X" if an Emergency Certification Statement is attached to this claim or entered in Box 19. Only one emergency indicator is allowed per claim and should be placed on the first line in Box 24I. If more than one is present, the first occurrence will be applied on the entire claim.
24J	**COB (Delay Reason).** N/A
24K	**Reserved for Local Use.** Enter the PHC provider number of the individual rendering provider only if it is different from the billing provider number.
24.2-24.6.	**Additional Claim Lines.** Follow instructions above for each claim line.
25	**Federal Tax I.D. Number**
26	**Patient's Account No.** Enter the patient's medical record number or account number in this field. Whatever is entered here will appear on the PHC Remittance Advice Report (RA).
27	**Accept Assignment.** N/A
28	**Total Charge.** In full dollar amount, enter the total for all services. Do not enter decimal point (.) or dollar sign ($). Enter full dollar amount and cents even if the amount is even. (e.g. If billing $20, enter 2000).
29	**Amount Paid.** Enter the amount of payment received from the Other Health Coverage (Box 11D) and/or the patient's co-pay amount. Do not enter decimal point (.) or dollar sign ($). Enter the full dollar amount and cents even if the amount is even.

ITEM	Description
30	**Balance Due.** Enter the difference between *Total Charges and Amount Paid.* Do not enter a decimal point (.) or dollar sign ($). Enter the full dollar amount and cents even if the amount is even.
31	**Signature of Physician or Supplier Including Degrees or Credentials.** The claim should be signed and dated by the provider or a representative assigned by the provider.
32	**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	Enter the NPI of the facility where the services were rendered.
32B	Enter the PHC additional provider number when required.
33	**Physician's Supplier's Billing Name, Address, Zip Code and Phone Number.** Enter the provider name, address, zip code, and telephone number.
33A	Enter the billing provider's NPI
33B	Used for PHC additional provider numbers when appropriate only. Note: Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.