Completing a CMS 1500 Form

CMS-1500

So you want to submit clean paper claims!

Most offices submit electronic claims, but there are still small offices that submit paper claims and other times when a paper claim is simply the easiest way to go.

CMS-1500

The claim form itself is split into three sections:

- Fields 1-13 are for patient information
- Fields 14-24 are for procedural and diagnostic information related to services provided
- Fields 25-33 are for servicing and billing provider information.

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To reinforce the concept of the three separate sections, we will be learning the information required to correctly complete the claim form based on the section requirements with questions related to what you just learned, immediately following each section, ending with a scenario in which you will create a clean 1500 claim based on the information given.

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In the office situation, all information required to complete the CMS form is found:

- Patient's registration form (section 1),
- Superbill and (to verify information) in the medical chart (section 2).
- The provider and billing provider information will be found in your billing (or front) office (section 3).

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Information you should know BEFORE you start:

1. Form should be printed or typed in one color ink; preferably black, so it will copy well.
2. Use no punctuation, except where directed, and stay inside the lines
3. All date formats, even though form states MMDDYY, should be written in MMDDYYYY format.
4. NO WHITE OUT or cross outs allowed!

Be aware that different insurance companies have differing regulations about how you are required to complete their claims.

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National Provider Identifier or **NPI** is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

- The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers. The transition to the NPI was ***mandated*** as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans were required by regulation to use only the NPI to identify covered healthcare providers by May 23, 2007.

- All individual HIPAA covered healthcare providers (physicians, physician assistants, nurse practitioners, dentists, chiropractors, physical therapists, etc.) or organizations (hospitals, home health care agencies, nursing homes, residential treatment centers, group practices, laboratories, pharmacies, medical equipment companies, etc.) must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction. Once assigned, a provider's NPI is permanent and remains with the provider regardless of job or location changes.

- The NPI number can be obtained online through the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

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Enter the carrier name and address where the claim is being submitted in the top right corner.


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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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

Box 1: Place an X (not a check mark!) in the appropriate box to represent the type of Insurance Plan being billed. Note that the box is to the left of the Insurance Plan.

Rationale: Computers will not recognize a check mark

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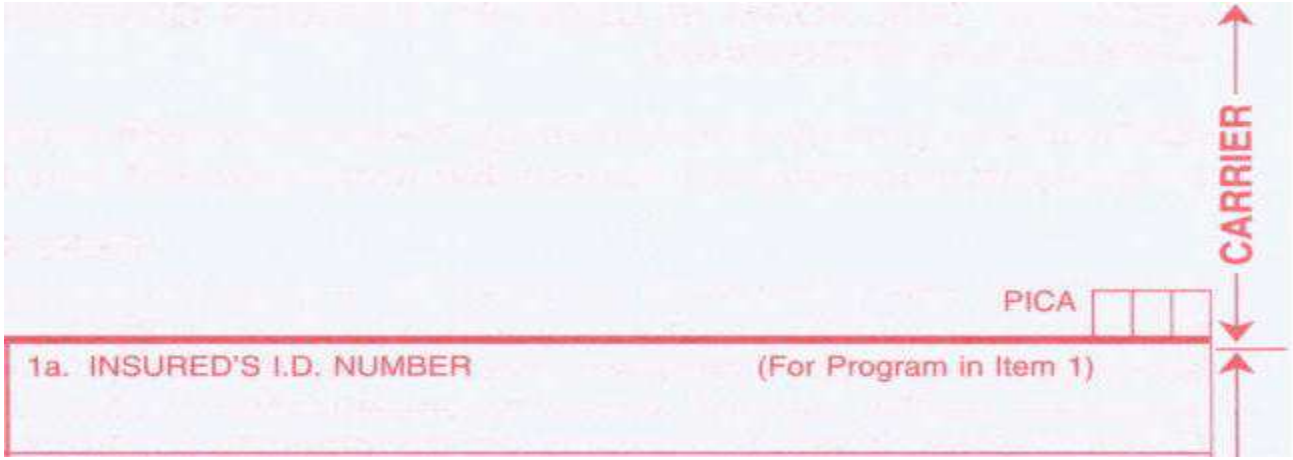
Box 1a: Insert the insured's ID number. (Remember this can be listed as a subscriber number, member number, beneficiary ID, etc.) This number represents one person, not a group!



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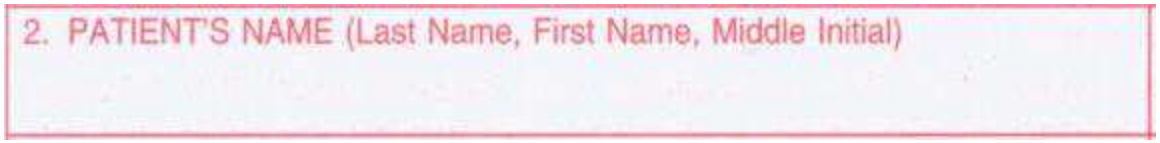
Box 2: Insert the patient's name using this format:
Last name, First name, Middle initial.



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Box 3: Patient's DOB. Remember MMDDYYYY format. Then place an X in the appropriate box representing the patient's sex.

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Box 4: If the patient is NOT the insured: Enter the Insured name in this format: Last name, First name, Middle initial.

If the patient IS the insured: Write the word SAME.
For MEDICARE Patients: Leave this box blank
Rationale: A Medicare number identifies only one person

Box 6 and Box 7 – relate to relationship to insured.

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Box 5: Enter the patient's address, city, state (2 letter abbreviations), zip code and phone number (including area code).

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Important: Boxes 9a-d are for the patient's secondary insurance coverage.
It might be easier to fill in fields 10 and 11 prior to 9 a-d;
9a-d will ONLY be completed if box 11d is marked YES

Box 9: Enter the Insured's name in this format:
Last name, First name and Middle Initial
If the patient is the insured, you may enter the word **SAME**
For MEDICARE Claims:
If Medigap plan, may leave blank

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Box 9a: Enter the Insured's Policy number and the Group Number (if known) in this format: 123456789 G12345

For MEDICARE Claims: Precede number by **MG**

Rationale: Denotes a Medigap secondary coverage

Box 9b: Enter the Insured's DOB (MMDDYYYY) format and place an X in the appropriate box to indicate the Insured's sex.

For MEDICARE Claims: If Medigap plan, may leave blank

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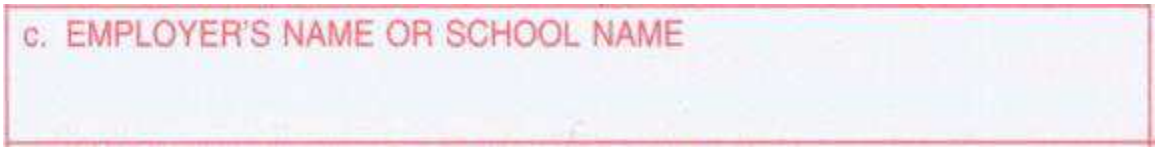
Box 9c: Enter the Insured's Employer Name

For MEDICARE Claims: If a Medigap - Payer ID is entered in item 9D, leave blank, otherwise enter the Carrier's Claim Address



Box 9d: Enter the name of the 2ndary Insurance Carrier

For MEDICARE Claims: If the Medigap Payer ID is not known, enter Medigap plan name.

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Box 10a-c: Place an X in the relevant YES or NO box to indicate whether patient's present condition is due to employment, auto accident or other accident.

Note: If any of these are marked yes, the carrier may question primary liability as Workers Comp, auto insurer or other liability insurance such as home owners coverage.

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Box 10d: Generally kept blank except in Medicaid secondary situations. (Some private carriers use this box for approved condition codes that may be found on the NUCC website www.nucc.org)

If Medicare and Medicaid: The patient's Medicaid number can be inserted here preceded by the prefix MCD.

If claim is for 2nd insurer: Insert *See Attached EOB*

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Box 11a-d: These boxes are filled out relating to the ***primary insurance*** coverage

Box 11: Fill in the Group policy number, if there is one. Do NOT insert the individual policy number a second time. Be sure that the **Group number** (identifying the employer or sponsoring group) goes here.

For MEDICARE Claims: Enter the word **NONE** and skip to 11d

Rationale: Tells Medicare that every attempt was made to locate any possible primary carrier before billing Medicare.

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Box 11a: <u>If the patient is NOT the insured:</u> Fill in the Insured's DOB
<u>If the patient IS the insured:</u> Leave blank.

Box 11b: Enter Employer's name.

Box 11c: Enter the name of the Primary Insurance Carrier.

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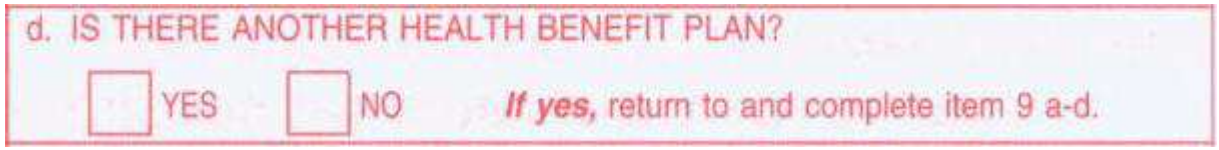
Box 11d: <u>If there IS a 2nd Insurance Plan</u>: Place an X in YES box and go to ***Box 9***
<u>If NO 2nd Insurance Plan</u>: Place an X in NO box and go to ***Box 12***

Rationale: If there is no secondary coverage, fields 9a-d are skipped



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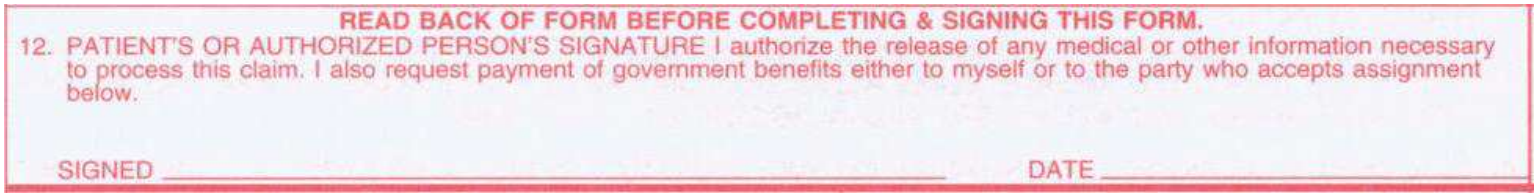
Box 12: Enter Signature on File (if you have a valid authorization to release medical records signed by the patient on file) or patient must sign the form

Rationale: Without the patient's signature, you do not legally have the right to release his or her protected health information (PHI) to the insurance carrier.


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 _____

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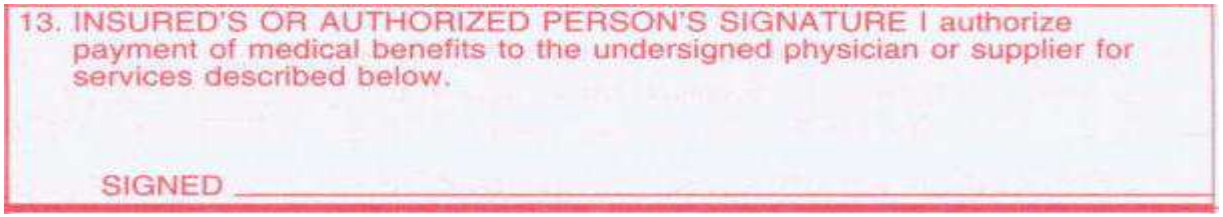
Box 13: Enter Signature on File (if you have a valid authorization to release medical benefits form signed by the patient) or ask the patient to sign the form here.

Rationale: Without a signature here, the insurance carrier may send the check to the patient instead of to your office. Unless your office requires payment in full at the time of service, it is best to have the payment sent to your office.


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 _____

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Section 1 Quiz

1. **Block 11 is completed with the patient's secondary insurance Plan ID#**
   - A. True
   - B. False
2. **If box 11d is X as NO – then block 9 will be left blank.**
   - A. True
   - B. False
3. **YES answers in block 10 may indicate liability insurance is responsible**
   - A. True
   - B. False
4. **Field #1 indicates the type of insurance plan is being billed**
   - A. True
   - B. False
5. **Which field must contain X to denote a secondary insurance**
   - A. 9d
   - B. 10d
   - C. 11d
   - D. 17b

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Box 14: Fill the date of one of these (relevant to reason for treatment):

a) Date of first symptoms of current illness (may be same as date of service).
b)Date of LMP (Last Menstrual Period – relevant to OB/ GYN claims)
c) Date of Injury (as a result of any type of accident)

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Box 15: If patient has had a similar problem previously, fill in the date patient first reported the problem.

Note: *If this is a new insurance plan for the patient, a "pre-existing" condition rejection may occur if the condition was present prior to insurance coverage going into effect.*

For MEDICARE Claims: Leave blank, not required

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Box 16: If patient was unable to work, fill in the appropriate dates (MMDDYYYY)

For MEDICARE Claims: Filling in this field may indicate a primary group health plan should be billed prior to Medicare

If not applicable: Leave blank

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Box 17-17a: If patient was referred to your office by a physician, complete these fields.

For MEDICARE Claims: *Field is required for any of the following*:
Physician to physician referrals, TPN or enteral nutrition, immunosuppressive drugs, lab and radiology services, portable x-rays, and consults.

Box 17a: Should be left blank for Medicare.

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Box 17b Enter the referring provider's NPI here.

For MEDICARE Claims: If the provider is also the referral source, as with in-house labs or x-rays, fill in the provider's name and title in Box 17 and his/her appropriate NPI in 17b.

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Box 18: If the patient was hospitalized during this billing period, fill in the hospitalization dates. (MMDDYYYY)

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Box 19: Usually leave blank, unless private payer requires use of this field. The qualifiers and ID numbers, if NPI is not available are listed in the table given with the instructions for fields 24I and J.

For MEDICARE Claims: *For PT or OT claims*, enter date last seen by therapist and supervising physician's NPI (or above listed alternate)

For Routine Foot Care: Enter the date and NPI of the attending physician when the physician providing routine foot care is submitting a claim.

If Modifer-99 (multiple modifiers) is used in 24 D, list each line item number and applicable modifier(s) here.

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Box 20: Enter an 'X' in the NO box unless your office allows a laboratory to bill you for patient services and then your office agrees to bill the patient for the lab charges.

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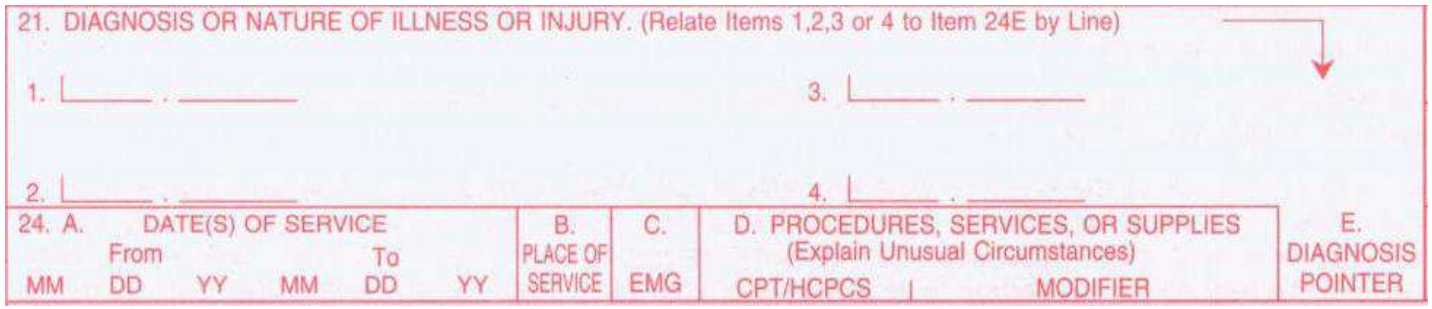
Box 21: Diagnosis codes: Fill in the Principal Diagnosis in #1 and then secondary diagnosis in descending order of importance. You may include up to 4 diagnosis codes per claim.

Note: Medicare is to increase this number to 8. Follow the carrier instructions regarding the number of diagnoses allowed


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

1. L_____ . _____ 3. L_____ . _____

2. L_____ . _____ 4. L_____ . _____

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

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Box 22: Used for Medicaid resubmissions only. If claim is for Medicaid resubmission, enter resubmission code and the original reference number as directed.

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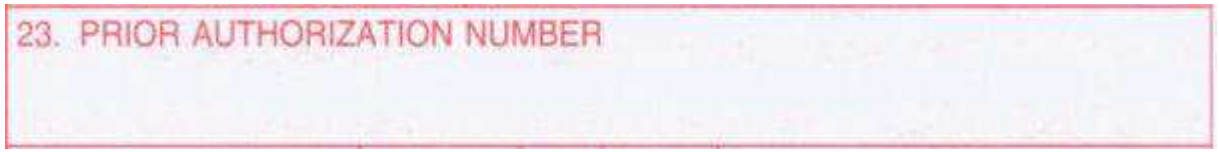
Box 23: Field is used by insurance plans when prior authorization is needed before an elective procedure can be done. The authorization number is placed in block 23. *Rationale:* If missing, approved procedure may be denied for payment.

For MEDICARE claims: If your office has a CLIA authorization number for lab work provided in your office, enter it here.

Also Note: Only one authorization can be entered per claim. If both a pre-authorized service and CLIA labs were performed, separate forms must be submitted.



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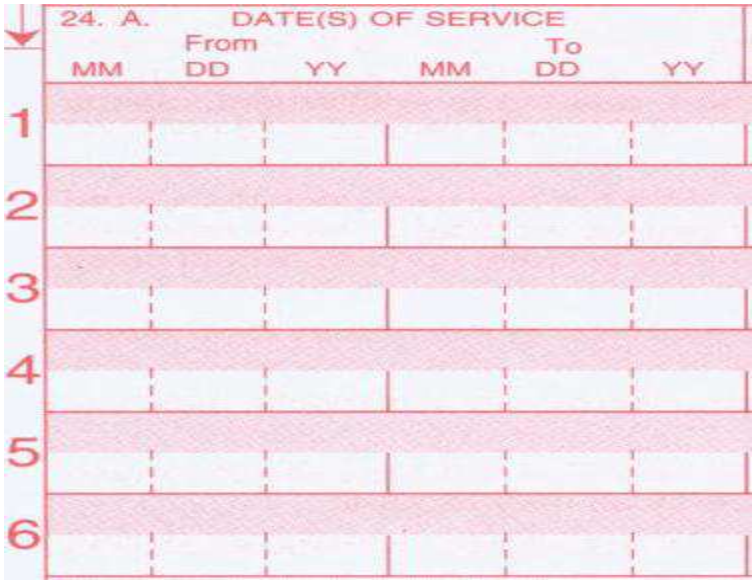
Box 24 A-J: Procedures and services provided to the patient. Each area is explained below. Only 6 procedures can be submitted per claim form.

Box 24A: Insert date of service in the "from" area. Unless there is more than one date to cover the service, the "to" area should be left blank.



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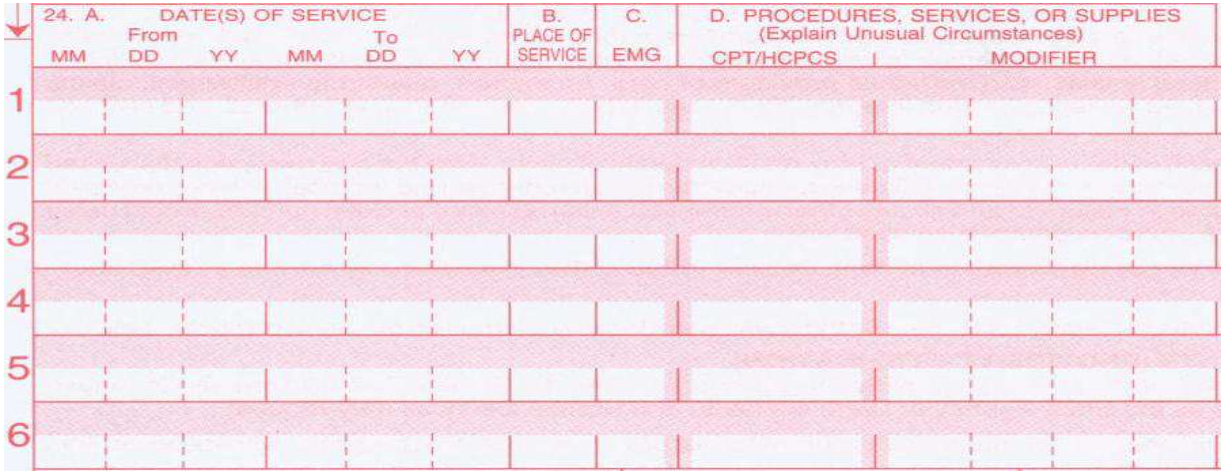
Box 24B: Place of Service code is entered here. A full list is found at:
http://www.cms.hhs.gov/PlaceofServiceCodes/Downloads/POSDataBase.pdf



	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
1										
2										
3										
4										
5										
6										

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POS Code	POS Name	POS Description
01	Pharmacy	Facility or location where drugs and other medically related items and services are sold, dispensed or otherwise provided directly to patients (effective 10/1/05)
03	School	Facility whose primary purpose is education
11	Office	Location, other than hospital, SNF, military treatment facility, community health center, State or local public health clinic or ICF, where health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hour/day, 7 days/week, with capacity to deliver or arrange for services including some health care and other services (effective 10/1/03)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention
21	Inpatient Hospital	Facility, other than psychiatric, which primarily provides diagnostic, therapeutic (surgical and nonsurgical), and rehab services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	Portion of a hospital which provides diagnostic, therapeutic (surgical and nonsurgical), and rehab services to sick or injured persons who do not require hospitalization or institutionalization.
23	ED – Hospital	Portion of hospital where emergency diagnosis and treatment of illness or injury is provided
24	Ambulatory Surgical Center	Freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
31	SNF	Facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital
32	Nursing Facility	Facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular bsis, health-related care services above the level of custodial care to other than mentally retarded individuals.
34	Hospice	Facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance – Land	Land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured
65	ESRD Treatment Facility	Facility other than a hospital, which provided dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

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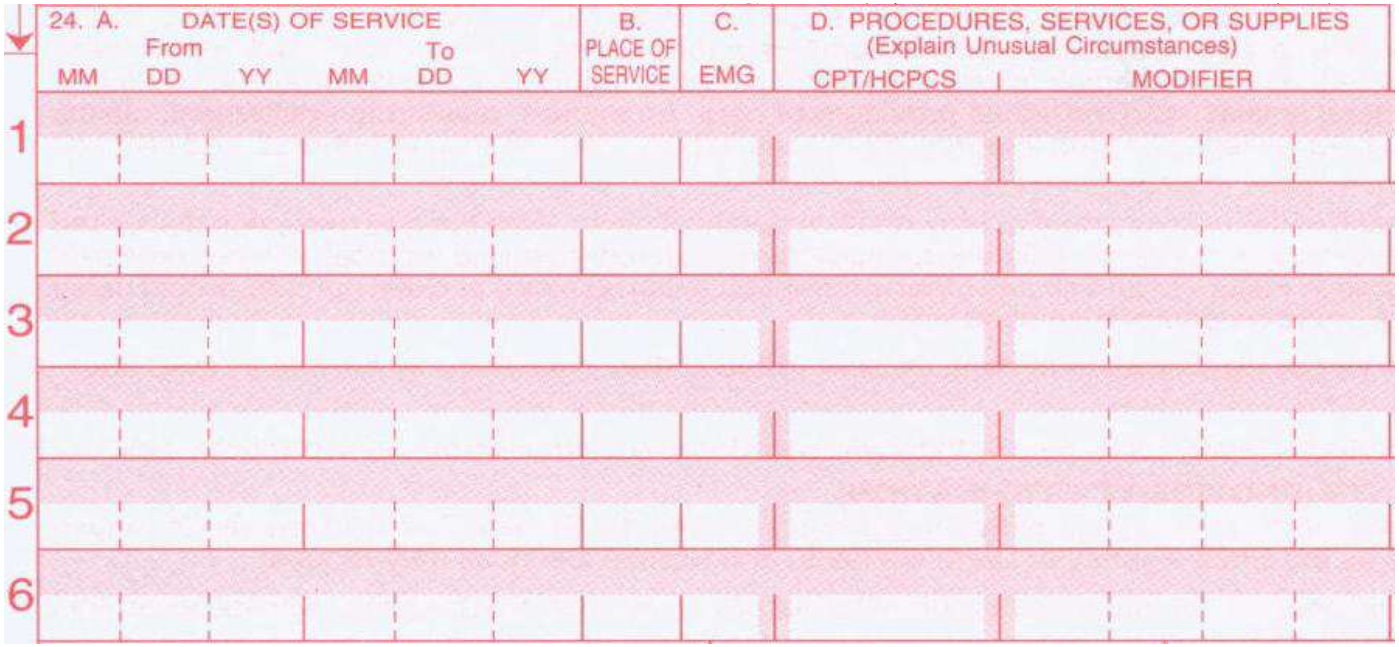
Box 24C: Emergency Indicator. Check with carrier as to necessity of completing this area. If required, in the non shaded area, enter Y for Yes and N for No denoting whether care was provided on emergency basis or not.



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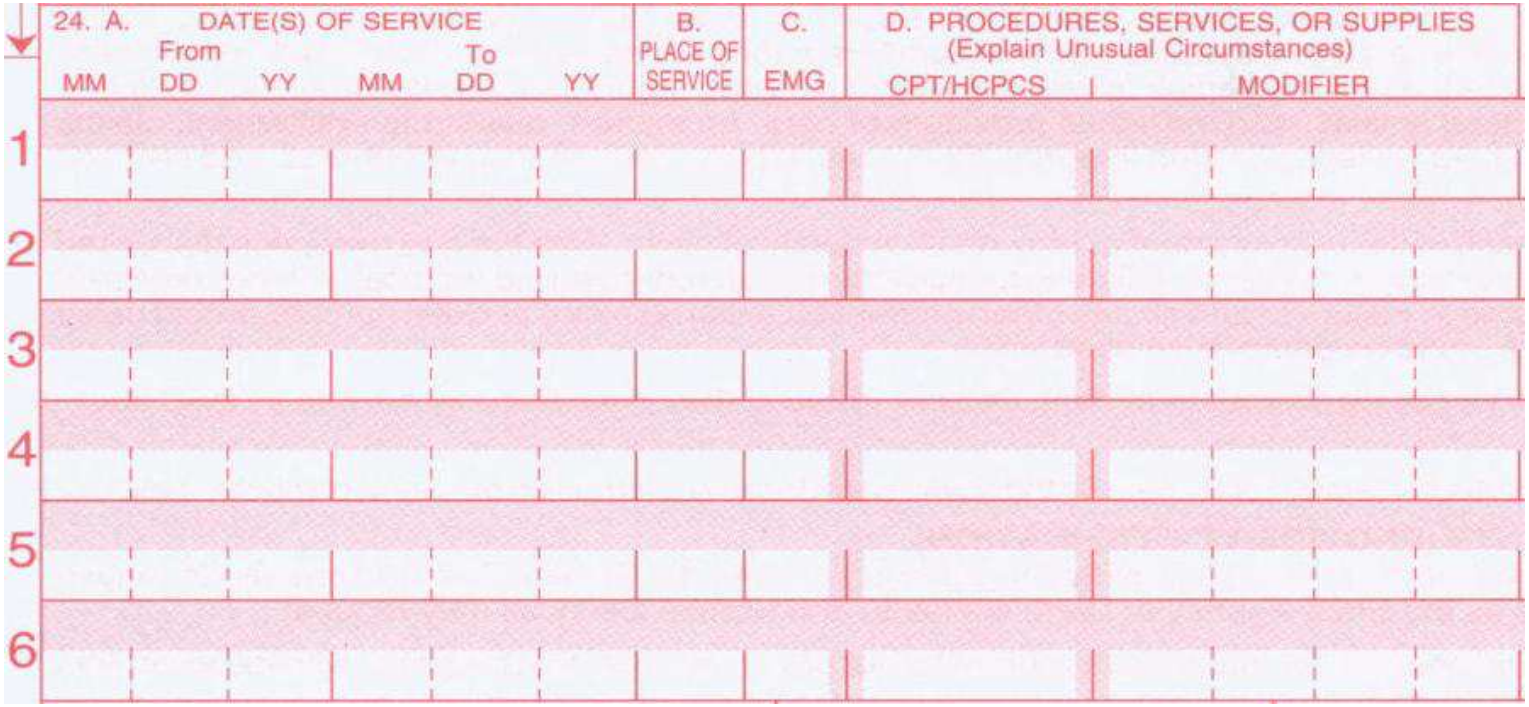
Box 24D: CPT codes and modifiers (if used)



	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
1										
2										
3										
4										
5										
6										

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Box 24E: Using number indicators; 1, 2, 3, or 4; match each procedure to the related diagnosis code listed in ***Box 21***.

Non-MEDICARE claims:

a) Enter up to 4 indicators per line. Use no commas between indicators

b) Use all Diagnosis codes in Block 21

For MEDICARE Claims:

a) Use ONLY 1 indicator per line.

b) Use all Diagnosis codes in Block 21.

E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	

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Box 24F: Insert the charge for each procedure listed

E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	

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Box 24G: Insert the units (or number of days, anesthesia or oxygen units) for each procedure.

Box 24H: Used for EPSDT and Family Planning programs. EPSDT stands for early, periodic, screening, diagnosis, and treatment of Medicaid recipients, 21 years and younger.

Enter a "Y" for Yes or "N" for No in the un-shaded area if services were for EPSDT or family.

E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	

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Using the table below, enter the appropriate qualifier in the shaded area of field 24I and the referenced identifier in field 24J. The same concept will apply to the shaded areas of 32b and 33b.

Note: **These qualifiers and ID numbers may be used in fields 24I, 24J, 32b & 33b**

0B State License Number
1B Blue Shield Provider Number
1C Medicare Provider Number
1D Medicaid Provider Number
1G Provider UPIN Number
1H CHAMPIS Identification Number
E1 Employer's Identification Number
G2 Provider Commercial Number
LU Location Number
N5 Provider Plan Network Identification Number
SY Social Security Number (SSN may not be used for Medicare)
X5State Industrial Accident Provider Number
ZZ Provider Taxonomy

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Box 24I ID Qualifiers with ID numbers or NPI numbers

<u>If required by a primate insurer, enter qualifier ID</u>: Enter qualifier in shaded box

<u>For all other payers including Medicare :</u> Leave blank

E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	

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Box 24J Identification of service provider

If required by payer: Enter non-NPI ID number in shaded area, Everyone else, including Medicare, leave blank.

E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	
				NPI	

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Section 2 Quiz

1. **Medicaid is the first payer to allow up to 8 diagnoses per claim**
   - A. True
   - B. False
2. **Box 24 refers to LMP which means?**
   - A. Last medical provider
   - B. Last menstrual pain
   - C. Last menstrual period
   - D. Last menopausal period
3. **What POS codes is used for ambulance services?**
   - A. 01
   - B. 20
   - C. 24
   - D. 41
4. **How many procedures/services are allowed per claim?**
   - A. 12
   - B. 10
   - C. 8
   - D. 6

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Box 25: Enter the Provider's Federal Tax ID number or SSN.

If using the Provider's personal SSN, place an 'X' in the SSN box.

If it is an EIN (Employer Identification Number; Federal Tax ID #) then place in 'X' in the EIN box.

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Box 25: Enter the Provider's Federal Tax ID number or SSN.

If using the Provider's personal SSN, place an 'X' in the SSN box.

If it is an EIN (Employer Identification Number; Federal Tax ID #) then place in 'X' in the EIN box.

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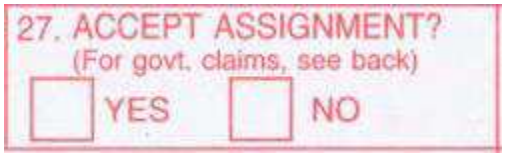
Box 26: Enter the patient's internal 'account number' for your facility, if applicable.

Box 27: Place an 'X' in the YES box to accept assignment for the claim or No if assignment is not accepted.

Rationale: This indicates that the provider is accepting the allowed charge as payment in full and that the check should go directly to him/her.



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Box 28-30: Indicates total charge, any prior insurance payments received and the balance due.

For MEDICARE Claims: Medicare does not require boxes 29 and 30 to be completed. If Medicare is the secondary, enter the amount paid by the primary carrier and balance due as being submitted to Medicare.

Rationale: As primary carrier, Medicare bases payment on the allowed charge, which is based on the provider's fee schedule. Entering patient payment would appear to change this fee schedule.

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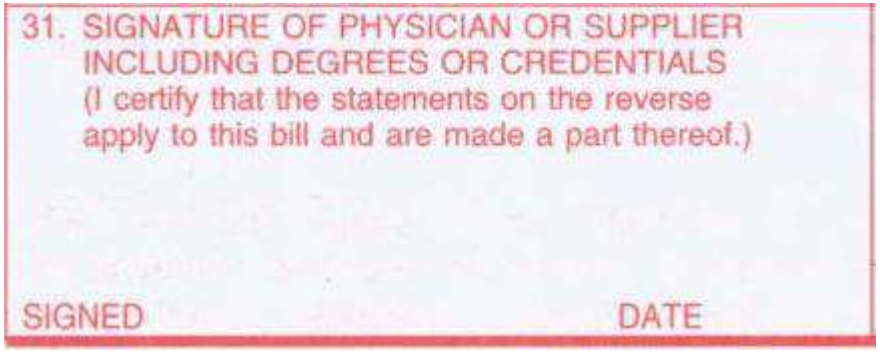
Box 31: Provider's signature or supplier, credential and date. (Must be legible)

Rationale: Signature verifies procedures on claim were provided to patient



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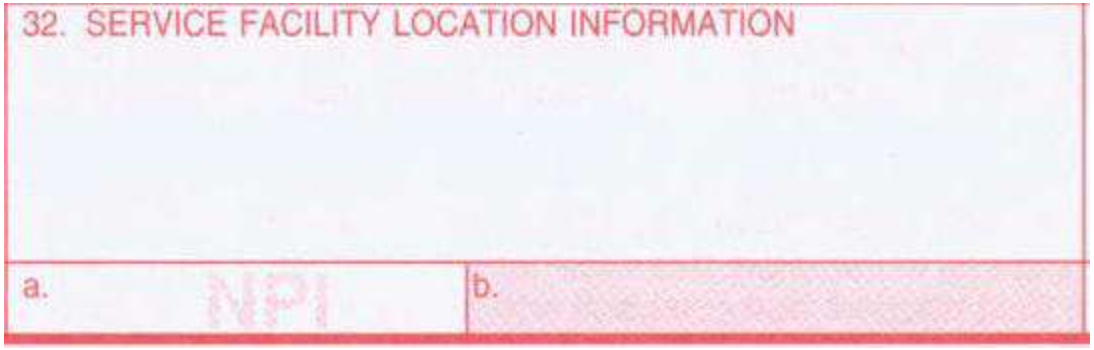
Box 32: Service Facility Location: Enter name on first line, address on second line, city, state and zip code on third line, of location where services were provided. Use no punctuation except for hyphen when using a 9 digit zip code.

For all facilities: Enter NPI number in **Box 32a**

If required by payer: Enter appropriate qualifier (listed previously) and provider number in

Box 32b. Enter no spaces, hyphen or other separator between the two numbers.



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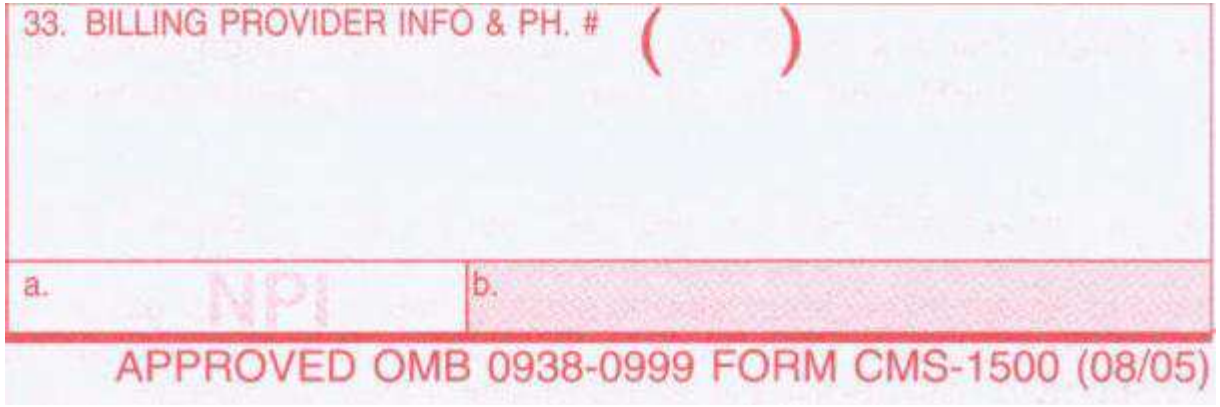
Box 33: Billing Provider Information and phone number. Use the same set up as with the Service Facility Location in Box 32. Telephone number will go on line 4. Use no hyphens or spaces within the telephone number. Use hyphen only for 9 digit zip code.

For all Providers:Enter NPInumber in**Box33a**

If required by payer: Enter appropriate qualifier (listed previously) and provider number in**Box33b**.Enter no spaces, hyphen or other separator between the two numbers.



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Section 3 Quiz

1. **The billing provider must list his/her phone number in block 33**
   - A. True
   - B. False
2. **If there is no signature in block 31, the claim will likely be denied**
   - A. True
   - B. False
3. **The billing provider information is found in block 32 and that of the treating facility is found in block 33**
   - A. True
   - B. False
4. **Accepting assignment means that the patient will not get billed**
   - A. True
   - B. False
5. **Which block is optional, depending on office policy**
   - A. 25
   - B. 26
   - C. 29
   - D. 32

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Using the basic guidelines, complete the blank CMS form for a commercial carrier using the information provided here:

Patient Information:

Mari Lou Walin		DOB:	4/12/60
82 Main Street		SSN:	111-22-3344
Anytown, US 00000		Employer:	State of US
555-123-4567		Dpouse:	John J

Insurance Information:

Carrier:	Aetna	Policy #:	1003198302
Insured:	Mari Lou	Group #:	US8901

Authorization to release information and assignment of benefits to provider, both on file

Provider Information:

David A. Dodoc, M.D.	EIN:	89123502
Medical Care East	Provider NPI:	1029384756
5192 Welbeing Way	Facility NPI	6758493021
Alltowns, US 11111		
555-987-6543		

Appointment Information (Use today's date)

New Patient Level III	99203	$ 90.00
ECG	93000	$ 85.00
Venipuncture (Lipid Panel)	36415	$ 25.00

Diagnoses

Chest Pain	786.50
Family Hx Heart Disease	V17.4
Hypertension	401.9

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Medical Billing and Coding Resources

AAPC – American Academy for Professional Coders www.aapc.com
AMBA – American Medical Billing Association www.ambanet.net
AHIMA – American Health Information Management Association – www.ahima.org
CMS - Centers for Medicare and Medicaid – www.cms.gov

Coding Manuals

International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM)
Current Procedural Terminology (CPT®)
Heath Care Common Procedure Coding System (HCPCS)

CMS1500 Forms

In order to purchase claim forms, you should contact the U.S. Government Printing Office at 1-866-512-1800, local printing companies in your area, and/or office supply stores. Each of the vendors above sells the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc).

Questions???