8 Billing on the CMS 1500 Claim Form

Reviewed/Revised: 10/10/2017, 02/01/2017, 02/15/2016, 09/16/2015, 09/18/2014

INTRODUCTION

The CMS 1500 claim form is used to bill for non-facility services, including professional services, freestanding surgery centers, transportation, durable medical equipment, ambulatory surgery centers and independent laboratories

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SUCCESSFUL CMS 1500 CLAIM SUBMISSION TIPS

Format:

- ☐ Do not print, hand-write, or stamp any extraneous data on the form.
- ☐ No hand-written corrections, no highlighting.
- ☐ Enter all information on the same horizontal plane within the designated field.
- ☐ Ensure data is in the appropriate field and does not overlap into other fields.
- ☐ Use individual's name in provider signature, not a facility or practice name.

Accurate information is key:

- ☐ Put member's name and ID number as it appears on member card
- ☐ Include all applicable NPI numbers
- ☐ Indicate the correct address including ZIP code where service was rendered, making sure address was reported to Network Representative and added to the Health Choice Arizona provider database
- ☐ Ensure that the # of units/days and the dates of service range are not contradictory
- ☐ Ensure that the quantity indicated in the procedure codes description are not contradictory

Coding tips:

- ☐ Assign current ICD-10 diagnosis codes and code them to the highest level of specificity available.
  - ☐ Primary diagnosis
    - o The primary diagnosis should describe the main condition or symptom of the patient.
    - ☐ Secondary/Additional Diagnosis

- This field should be used if there is a secondary and/or additional conditions or symptoms that affect the treatment.
- Diagnosis which relate to a previous illness and which have no bearing on the current encounter should not be reported.

- ☐ The number of anesthesia minutes should always be reported on each claim in Field 24G.
- ☐ Use current valid CPT and HCPCS codes.
- ☐ Use current valid modifiers when necessary.

DOCUMENTATION REQUIREMENTS

Providers must include all required documentation with the claim submission. Failure to do so may result in denial of the claim. Health Choice Arizona reserves the right to request additional documentation of the claim.

COMPLETING THE CMS 1500 CLAIM FORM

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.”

1. Program Block Required

Check the second box labeled “Medicaid”:

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(Medicare#)*	☒ *(Medicaid#)*	☐ *(ID# / DoD#)*	☐ *(member ID #)*	☐ *(ID#)*	☐ *(ID#)*	☐ *(ID#)*

1a. Insured's ID Number **Required**

Enter the recipient's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, review eligibility via the Health Choice Arizona Provider Portal or contact Health Choice Arizona at (800) 322-8670. (See Chapter 2: Member Eligibility and Member Services).

1a. INSURED'S ID NUMBER(FOR PROGRAM IN ITEM 1)
A12345678

2. **Patient's Name** **Required**
Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

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

3. **Patient's Date of Birth and Sex** **Required** Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE			SEX
MM	DD	YY	
08	14	1851	M ☒ F ☐

4. **Insured's Name** **Not required**

5. **Patient Address** **Not required**

6. **Patient Relationship to Insured** **Not required**

7. **Insured's Address** **Not required**

8. **Reserved for NUCC Use** **Not required**

9. **Other Insured's Name** **Required if applicable** If the recipient has no coverage other than Health Choice Arizona, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. **Other Insured's Policy or Group Number** **Required if applicable if**
Enter the group number of the other insurance.

9b. **Reserved for NUCC Use** **Not required**

9c. **Reserved for NUCC Use** **Not required**

9d. **Insurance Plan Name or Program Name** **Required if applicable**
Enter name of insurance company or program name that provides the insurance coverage.

10. **Is Patient's Condition Related to:** **Required if applicable**
Check "YES" or "NO" to indicate whether the patient's condition is related to employment,

an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)

☒ YES ☐ NO

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☒ NO

c. OTHER ACCIDENT?

☐ YES ☒ NO

10d. Claim Codes (Designated by NUCC) **Not Required**

11. Insured's Group Policy or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

11b. Other Claim ID (Designated by NUCC) **Required if applicable**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**

Check the appropriate box to indicate coverage other than Health Choice Arizona. If "Yes" is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Not required**

13. Insured's or Authorized Person's Signature **Not required**

14. Date of Illness or Injury **Required if applicable**

15. Other Date **Not required**

16. Dates Patient Unable to Work in Current Occupation **Not required**

17. Qualifier / Name of Provider or Other Source **Required if applicable**

If applicable, enter the Qualifier:

DN Referring Provider
DK Ordering Provider*
DQ Supervising Provider

Then enter the Name of the Provider or Other Source

* The ordering provider is *required* for:

- ☐ Laboratory
- ☐ Radiology
- ☐ Medical and Surgical Supplies
- ☐ Respiratory DME
- ☐ Enteral and Parenteral Therapy
- ☐ Drugs (J-codes)
- ☐ Temporary K codes
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Temporary Q codes
- ☐ Vision codes (V-codes)
- ☐ 97001-97546

Ordering providers can be a M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

17a. ID Number of Provider **Required if applicable**

17b. NPI # of Referring Provider **Required**

18. Hospitalization Dates Related to Current Services **Not required**

19. Additional Claim Information **Required if applicable**

20. Outside Lab and ($) Charges **Not required**

21. Diagnosis Codes **Required**

Enter at least one *ICD-10 diagnosis code* describing the recipient's condition. Behavioral health providers must not use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. O139	B. O6012x0	C. J0190	D.
E.	F.	G.	H.
I.	J.	K.	L.

22. Medicaid Resubmission Code **Required if applicable**

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the Health Choice Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

This Item Number is not intended for use on original claim submissions.

DESCRIPTION: "Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

See Chapter 7: General Billing Rules, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
A	030010004321

23. Prior Authorization Number **Not required**

See Chapter 6: Medical Authorizations and Notifications, for information on prior authorization.

24A. Date(s) of Service and NDC (effective 7/1/12) **Required/NDC if applicable**

- ☐ In Field 24A of the CMS-1500 Form in the shaded area, enter the **NDC Qualifier** of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- ☐ The billed units in column **G** (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Servic	C EMG	D PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual) CPT/HCPCS	MODIFIER
N400074115278 ML10									
07	01	12	07	01	12	11		J1642	

The beginning and ending service dates must be entered in the non-shaded area.

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

1	Pharmacy	19	Off Campus-Outpatient Hospital	49	Independent Clinic
2	TeleHealth	20	Urgent Care Facility	50	FQHC
3	School	22	Outpatient Hospital	53	Community Mental Health Center
4	Homeless shelter	23	ER - Hospital	54	ICF/Mentally Retarded
5	IHS Free-standing Facility	24	ASC	55	Residential Substance Abuse Treat Facility
6	IHS Provider-based	25	Birthing Center	56	Psych Residential Treatment

7	Tribal 638 Free-standing Facility	26	Military Treatment Facility	57	Non-residential Substance Abuse Treatment Facility
8	Tribal 638 Provider-based Facility	31	Skilled Nursing Facility	60	Mass Immunization Center
11	Office	32	Nursing Facility	61	Comprehensive Inpatient Rehabilitation Facility
12	Home	33	Custodial Care Facility	62	Comprehensive Outpatient Rehabilitation Facility
13	Assisted Living Facility	34	Hospice	65	ESRD Treatment Facility
		41	Ambulance – Land	71	State or Local Public Health Clinic
14	Group Home	42	Ambulance – Air or Water	72	Rural Health Clinic
				81	Independent Laboratory

24. A DATE(S) OF SERVICE		B Place of	C	D PROCEDURE, SERVICES, OR SUPPLIES	
From	To		EMG	CPT/HCPCS	MODIFIE
		11			

24C. EMG- Emergency Indicator **Required if applicable**

Mark this box with a "check-mark" an "X," or a "Y" if the service was an emergency service, regardless of where it was provided.

24 A DATE(S) OF						B Place	C	D PROCEDURE, SERVICES, OR	
Fro			To			of		(Explain	Unusual
MM	DD	YY	MM	DD	YY	Servic	EMG	CPT/HCPCS	MODIFIE
							Y		

24D. Procedure and Procedure Modifier **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment. The modifier field allows for four sets of 2 characters

24 A DATE(S) OF SERVICE						B Place of Servic	C Type of Servic	D PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual	
Fro			To						
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
								71010	**26**

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
CPT/HCPCS	MODIFIER			
99241	25			

24E. Diagnosis Pointer Required

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance. **To avoid claim denials, ensure the diagnosis code referenced in this field has a direct relationship to the CPT/HCPC code billed.**

D PROCEDURE, SERVICES, OR SUPPLIES		E	F	G	H
CPT/HCPCS	MODIFIE	DIAGNOSIS	$ CHARGES	DAYS OR	EPSDT Famil
		1			
		1, 2			

24F. Charges $ Required

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D PROCEDURE, SERVICES, OR SUPPLIES		E	F	G	H
CPT/HCPCS	MODIFIE	DIAGNOSIS	$ CHARGES	DAYS OR	EPSDT Famil
			150 00		
			79 00		

24G. Days or Units Required

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES		DIAGNOS IS	$ CHARGES	DAY S OR	EPSD T Famil
CPT/HCPCS	MODIFIE				
				2	
				1	

24H. EPSDT/Family Planning **Not required**

24I. ID Qualifier **Required if applicable**

24J. Rendering Provider ID Number **Required**

(SHADED AREA) – Use for COB INFORMATION **Required if applicable**
Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient' Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount *paid.* Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.
See Chapter 14: Medicare and Other Insurance Liability, for details on billing claims with Medicare and other insurance.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID # **Required**
Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI number.

For atypical provider types, the AHCCCS ID must be used. The provider number is required in 24J if the NPI listed in 33A is not the same as the provider rendering services.

E DIAGNOSI S POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMIL Y PLAN	I ID QUAL	J RENDERING PROVIDER ID #
					COB Information
					NPI Rendering Provider NPI

25. Federal Tax ID **Required**
Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT ACCOUNT NO
86-1234567 ☐ x	

26. Patient Account Number **Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. Health Choice Arizona will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the Health Choice Arizona CRN and the provider's own accounting or tracking system.

27. Accept Assignment **Not required**

28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT (For govt claims, see back)	28. TOTAL		29. AMOUNT		30. Rsvd for	
YES NO	$ 179	00	$		$	

29. Amount Paid **Required if applicable**

Enter the total amount that the provider has been paid for this claim by all sources *other than Health Choice Arizona*. Do *not* enter any amounts expected to be paid by Health Choice Arizona.

30. Reserved for NUCC Use **Not required**

31. Signature and Date **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED John Doe DATE 03/01/03

32. Name and Address of Facility **Required if applicable** If the pay to address and the service address are the same, then box 32 is not required unless the rendering provider has multiple locations under the same TIN# then box 32 is required. **Box 32 CANNOT contain a post office box address; it must be a physical address.**

32. SERVICE FACILITY LOCATION INFORMATION
Arizona Hospital 123 Main Street Scottsdale, AZ 85252 a. NPI | b.

32a. Service Facility NPI **Required if applicable**
If the service facility location is indicated, service facility NPI# must be entered.

32b. Service Facility AHCCCS ID# (Shaded area) **Required if applicable**

33. Billing Provider Name, Address and Phone Number **Required**
Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI Number **Required if applicable**

33b. Other ID – AHCCCS # (Shaded area) Registration # **Required if applicable**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE	
Doc Holliday 123 OK Corral Drive Tombstone, AZ 85999	
a. NPI	b.

** **Note – NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, box 33b must be completed.**