CHAPTER 8:
Billing on the CMS 1500 Claim Form

Reviewed/Revised: 10/01/18, 01/01/19, 10/02/19, 1/1/20

8.0 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. FQHC services may also be billed on the CMS 1500 claim form. This chapter covers paper claim submission only, for additional information on electronic claim submission and general billing requirements please see Chapter 7 General Billing Rules.

The information is provided "as is" without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All models, methodologies and guidelines are undergoing continuous improvement and modification by Noridian Healthcare Solutions (Noridian) and the CMS. The most current edition of the information contained can be found on the Noridian website and the CMS website.

8.1 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.
- If required fields are not completed or if any fields are completed incorrectly, an error code will be identified for the claim. For example, if the date is “December 10, 2016” it must be recorded as 12/10/2016 (MM/DD/YYYY format).

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,
- 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
- If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456).
Coding tips:
- Assign current ICD-10 diagnosis codes and code them to the highest level of specificity available.
  - Primary diagnosis (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.

8.2 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#) [X] (Medicaid#) [ ] (ID# / DoD#) [ ] (member ID #) [ ] (ID#) [ ] (ID#)

1a. Insured’s ID Number Required
   Enter the recipient's AHCCCS ID number, whichever is applicable. If there are questions about eligibility or the AHCCCS ID number, review eligibility via the Health Choice Arizona Provider Portal, the AHCCCS online Eligibility System or contact Health Choice Arizona at (800) 322-8670 (see Chapter 2: Member Eligibility and Member Services for additional guidance).

   | 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  
   Date of Birth is Required
   Sex is Required if applicable

   Enter the recipient’s date of birth. Check the appropriate box to indicate the patient’s gender.

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  
   Required if applicable

   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)  Not Required

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  Required
   If the signature is on file, then stating that the signature is on file is acceptable.

13. Insured’s or Authorized Person’s Signature  Required if applicable

14. Date of Illness, Injury, or Pregnancy (LMP)  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
- Durable Medical Equipment
- 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
Any additional information required for the processing of a claim (that is not found in another field) shall be entered under the Additional Claim Information field. The standard format is as follows: FQHC/MSIC Indicator\Any other additional information.
For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the AHCCCS Fee-For-Service Provider Billing Manual.

20. Outside Lab and ($) Charges  
Not Required

21. Diagnosis Codes  
Required
Enter at least one ICD-10 diagnosis code describing the recipient’s condition. Diagnosis codes are required to the 6th/7th character level when applicable. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

Health providers must **not** use DSM-4 diagnosis codes
22. Medicaid Resubmission Code

Required if applicable
Enter the appropriate code “A” (paper) “7” for adjustment or “8” for void 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 Arizona 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." See Chapter 7: General Billing Rules, for information on resubmissions, adjustments, and voids.

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>030010004321</td>
</tr>
</tbody>
</table>

23. Prior Authorization Number

Not Required
If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456). See Chapter 6: 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.

<table>
<thead>
<tr>
<th>24.</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DATE(S) OF SERVICE</td>
<td>Place of Service</td>
<td>PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>MODIFIER</td>
</tr>
<tr>
<td></td>
<td>From M DD YY To M DD YY</td>
<td>EMG</td>
<td>CPT/HCPCS</td>
<td></td>
</tr>
<tr>
<td>N4</td>
<td>07 01 12 07 01 12</td>
<td>J1642</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>01</th>
<th>Pharmacy</th>
<th>19</th>
<th>Off Campus-Outpatient Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>TeleHealth</td>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>04</td>
<td>Homeless shelter</td>
<td>23</td>
<td>ER - Hospital</td>
</tr>
<tr>
<td>05</td>
<td>IHS Free-standing Facility</td>
<td>24</td>
<td>ASC</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>ICF/Mentally Retarded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treat Facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
06 IHS Provider-based Health Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
99 Other Place of Service
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance – Land
42 Ambulance – Air or Water
56 Psych Residential Treatment Facility
57 Non-residential Substance Abuse Treatment Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 ESRD Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DATE(S) OF SERVICE</strong>&lt;br&gt;<strong>From</strong> MM DD YY</td>
<td><strong>To</strong> MM DD YY</td>
<td><strong>Place of Service</strong> EMG</td>
<td><strong>PROCEDURE, SERVICES, OR SUPPLIES</strong> CPT/HCPCS <strong>MODIFIER</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

24C. EMG - Emergency Indicator
Required if applicable
Mark this box with a “Y” if the service was an emergency service, regardless of where it was provided.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DATE(S) OF SERVICE</strong>&lt;br&gt;<strong>From</strong> MM DD YY</td>
<td><strong>To</strong> MM DD YY</td>
<td><strong>Place of Service</strong> EMG</td>
<td><strong>PROCEDURE, SERVICES, OR SUPPLIES</strong> CPT/HCPCS <strong>MODIFIER</strong></td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

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.

<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>24.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DATE(S) OF Place</td>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From To Service</td>
<td>CPT/HCPCS MODIFIER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM DD YY MM DD YY</td>
<td>71010 26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>DIAGNOSIS POINTER</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1, 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>DIAGNOSIS CODE</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>150 00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79 00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

24I. ID Qualifier  
Required if applicable

24J. Rendering Provider ID Number  
Required

(SHADED AREA) – Use for Taxonomy Code  
Required if applicable

Use this SHADED field to report the provider’s 10 digit alpha-numeric Taxonomy Number.

NOTE: Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer’s EOB to the claim.

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.

25. Federal Tax  
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.

<table>
<thead>
<tr>
<th>27. ACCEPT ASSIGNMENT?</th>
<th>28. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. Rsvd for NUCC Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>(For govt claims. see back)</td>
<td>$179</td>
<td>$0</td>
<td>$</td>
</tr>
</tbody>
</table>

When submitting a claim with multiple pages (a multi-page claim) all lines must be completed on the first page, before proceeding to the second page of the claim. (Please note that only the required fields on all lines will need filled in.)

Multi-page claims should have the total charges field left blank. The total charges should only be entered on the last page of a multi-page claim.

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 ID # (Shaded area)  
**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. Taxonomy Code

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