

CMS-1500 Claim Form Instructions

This document is intended to provide Alaska Medicaid-specific instructions and clarifications for completion of the 1500 claim form, version 02/12. It is to be used as a **companion to, and not a replacement for**, the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, available at <http://nucc.org/>.

Each number listed in the instructions corresponds to a field on the CMS-1500 claim form; additional fields may be required for providers billing electronically in a HIPAA-compliant format.

These claim form instructions are intended for the following provider types/services:

- Advanced Nurse Practitioner/Nurse Midwife
- Audiologist
- Autism Services
- Behavioral Rehabilitation Services
- Care Coordinator/Care Coordination Agency
- Certified Registered Nurse Anesthetist
- Chiropractor
- Community Behavioral Health
- Community Health Aide/Practitioner
- Dietician
- Direct-Entry Midwife
- Durable Medical Equipment/Respiratory Therapy
- Early & Periodic Screening, Diagnosis, & Treatment
- Environmental Modifications
- Family Planning Clinic
- Federally Qualified Health Center/Rural Health Center
- Ground Ambulance Services
- Health Professional Group
- Home and Community Based Agency
- Home Infusion Therapy
- Independent Laboratory Services
- Indian Health Services & Tribal Services/Tribal Clinic
- Mental Health Physician Clinic
- Nutrition
- Personal Care Assistant/Agency
- Physician
- Physician Assistant
- Podiatry
- Private Duty Nurse
- Prosthetic and Orthotic Supplier
- Psychologist
- Radiology Services
- Residential Supported Living
- School-Based Services
- Targeted Case Management
- Therapies: Occupational, Physical, Speech-Language
- Vision Services



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <input type="checkbox"/> PICA <input type="checkbox"/>																	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoDA) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) 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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)										
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"/>					7. INSURED'S ADDRESS (No., Street)							
CITY			STATE		CITY			STATE		CITY			STATE				
ZIP CODE			TELEPHONE (Include Area Code)		ZIP CODE			TELEPHONE (Include Area Code)		ZIP CODE			TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.							
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.										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 _____					DATE _____					SIGNED _____							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____					15. OTHER DATE MM DD YY QUAL _____					18. 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. _____ 17b. NPI _____					19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____							
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER _____							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG _____		C. _____			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS _____ MODIFIER _____		E. DIAGNOSIS POINTER _____	F. \$ CHARGES _____	G. DAYS ON UNITS _____	H. EPDT Family Plan _____	I. ID. QUAL _____	J. RENDERING PROVIDER ID. # _____			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15			
25. FEDERAL TAX I.D. NUMBER _____			26. PATIENT'S ACCOUNT NO. _____		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____		30. Reserved for NUCC Use						
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.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()							
SIGNED _____					DATE _____					a. NPI _____		b. _____		a. NPI _____		b. _____	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample CMS-1500 Claim Form

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions								
1.	Medicare/Medicaid/TRICARE/etc.	M	Select Medicaid . For Medicare crossover claims, select Medicaid and Medicare .								
1a.	Insured's ID Number	M	Enter the Medicaid-eligible patient's (recipient's) 10-digit Medicaid identification number.								
2.	Patient's Name	M	Enter the Medicaid recipient's name as it appears on the eligibility card or coupon.								
3.	Patient's Birth Date, Sex	O									
4.	Insured's Name	O	Medicaid recipient is always the insured.								
5.	Patient's Address	O									
6.	Patient's Relationship to Insured	M	Select Self (see field 4).								
7.	Insured's Address	O									
8.	Reserved for NUCC Use	B									
9.	Other Insured's Name	C	Complete if the recipient has other insurance (as indicated in field 11d).								
9a.	Other Insured's Policy or Group #	C	Exception: If an approved TPL avoidance record applies to the services billed, leave blank .								
9b.	Reserved for NUCC Use	C	Required for ambulance providers Complete if there are attachments to the claim. Enter the code that corresponds to the type of documentation attached: <table border="1" data-bbox="856 1036 1598 1203"> <thead> <tr> <th>Code</th> <th>Type of Documentation</th> </tr> </thead> <tbody> <tr> <td>CK</td> <td>Sterilization Consent Form</td> </tr> <tr> <td>EB</td> <td>Explanation of Benefits</td> </tr> <tr> <td>OZ</td> <td>Support Data for Claim / Medical Justification</td> </tr> </tbody> </table>	Code	Type of Documentation	CK	Sterilization Consent Form	EB	Explanation of Benefits	OZ	Support Data for Claim / Medical Justification
Code	Type of Documentation										
CK	Sterilization Consent Form										
EB	Explanation of Benefits										
OZ	Support Data for Claim / Medical Justification										
9c.	Reserved for NUCC Use	B									
9d.	Insurance Plan Name or Program Name	C	Complete if the recipient has other insurance (as indicated in field 11d). Exception: If an approved TPL avoidance record applies to the services billed, leave blank .								
10a.	Is Patient's Condition Related to Employment?	M									

Claim Field Identification		M: Mandatory C: Mandatory- Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
10b.	Is Patient's Condition Related to Auto Accident?	M	
10c.	Is Patient's Condition Related to Other Accident?	M	
10d.	Claim Codes (Designated by NUCC)	C	An attachment is required for each reported code. Refer to the provider billing manual for details on attachment requirements for abortion and sterilization services.
11.	Insured's Policy, Group, or FECA Number	C	For Medicare crossover claims, enter Medicare , even if another TPL exists.
11a.	Insured's Date of Birth, Sex	C	Use to report TPL-related insured's information, only.
11b.	Other Claim ID (Designated by NUCC)	C	Use to report TPL-related information, only.
11c.	Insurance Plan Name or Program Name	B	
11d.	Is There Another Health Benefit Plan?	M	Choose yes to report health plans other than Medicaid.
12.	Patient's or Authorized Person's Signature	M	
13.	Insured's or Authorized Person's Signature	M	
14.	Date of Current Illness, Injury, or Pregnancy (LMP)	O	If date is reported, applicable qualifier is required.
15.	Other Date	O	
16.	Dates Patient Unable to Work in Current Occupation	O	
17.	Name of Referring Provider or Other Source	C	Referring, ordering, and prescribing providers must be enrolled with Alaska Medical Assistance. If the recipient is enrolled in the Care Management Program and rendering provider is not the primary care provider (PCP), a copy of the PCP's referral must be attached to the claim.
17a.	Other ID#	C	Required if a provider is entered in field 17.

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions																						
17b.	NPI #																								
18.	Hospitalization Dates Related to Current Services	B																							
19.	Additional Claim Information (Designated by NUCC)	O																							
20.	Outside Lab? \$ Charges	B																							
21.	Diagnosis or Nature of Illness or Injury	M	<p>Required of all provider types. Enter 0 to indicate ICD-10 diagnosis codes. Enter the appropriate diagnosis code(s) in A – L. Only ICD-10 diagnosis codes will be accepted.</p> <p>Atypical/Non-Diagnosing Providers: Alaska Medicaid recommends the following providers use the following diagnosis codes when a documented diagnosis is not known.</p> <table border="1"> <thead> <tr> <th>Services</th> <th>ICD-10</th> </tr> </thead> <tbody> <tr> <td>Behavioral Rehabilitation</td> <td>Z74.8</td> </tr> <tr> <td>Care Coordination Agency</td> <td>Z02.9</td> </tr> <tr> <td>Environmental Modification</td> <td>Z59.1</td> </tr> <tr> <td>Home and Community Based Agency</td> <td>Use plan of care diagnosis</td> </tr> <tr> <td>Hotel</td> <td>Z75.3</td> </tr> <tr> <td>Personal Care Agency</td> <td>Z74.1</td> </tr> <tr> <td>Pre-Maternal Home</td> <td>Z75.8</td> </tr> <tr> <td>Residential Supported Living</td> <td>Z74.8</td> </tr> <tr> <td>School-Based Services</td> <td>Use IEP diagnosis</td> </tr> <tr> <td>Taxi</td> <td>Z75.3</td> </tr> </tbody> </table>	Services	ICD-10	Behavioral Rehabilitation	Z74.8	Care Coordination Agency	Z02.9	Environmental Modification	Z59.1	Home and Community Based Agency	Use plan of care diagnosis	Hotel	Z75.3	Personal Care Agency	Z74.1	Pre-Maternal Home	Z75.8	Residential Supported Living	Z74.8	School-Based Services	Use IEP diagnosis	Taxi	Z75.3
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Taxi	Z75.3																								
22.	Resubmission and/or Original Reference Number	B																							
23.	Prior Authorization Number	C	If service billed requires authorization, enter the alpha-numeric prior (service) authorization ID .																						

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
	Section 24	C	In the shaded area of section 24, enter supplemental information to support the billed service. Refer to Section II: Professional Claims Management for examples. For J Codes , record the following in the shaded area of the claim line. Do not insert spaces or hyphens. <ol style="list-style-type: none"> 1. N4 qualifier 2. 11-digit NDC number, 3. NDC unit of measure, and 4. NDC units administered. Example: N4XXXXXXXXXXXXML1.0
24a.	Date(s) of Service	M	Submit single dates of service only; spanned dates will be denied.
24b.	Place of Service	M	
24c.	EMG	C	Note: Emergency services are not subject to cost sharing. Refer to provider billing manuals for definition of emergency.
24d.	Procedures, Services, or Supplies	M	
24e.	Diagnosis Pointer	M	
24f.	\$Charges	M	
24g.	Days or Units	M	If the recipient is a resident of a long-term-care facility, enter LTC in the shaded area. For J Codes, use the NCPDP billing unit standard for the medication; correct billing units are available at http://www.ncdp.org/standards/standards-quick-forms.aspx .
24h.	EPSDT/Family Plan	C	Alaska Medicaid requires reporting EPSDT related services. Use the appropriate reason code found in the NUCC manual to represent the EPSDT-related service . Enter Y in the unshaded area if the service is family planning.
24i.	ID Qualifier	C	Typical (NPI) Providers: Alaska Medicaid strongly recommends indicating the rendering provider's taxonomy and qualifier ZZ. Atypical Providers: Enter qualifier G2 in the shaded area.

Claim Field Identification		M: Mandatory C: Mandatory- Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
24j.	Rendering Provider ID #	C	Refer to your Alaska Medicaid provider billing manual to determine if you are required to identify the rendering provider on your claims. Typical (NPI) Providers: In the shaded area, enter the rendering provider's taxonomy/Medicaid Contract ID as indicated by field 24i. Atypical Providers: Enter 7-digit provider ID number.
25.	Federal Tax ID Number	O	
26.	Patient's Account No.	O	If used, this provider-assigned account number will appear on the remittance advice.
27.	Accept Assignment?	M*	*Required of all providers except the following, which should leave field blank : <ul style="list-style-type: none"> • Environmental Modifications • Home and Community-Based Agency • Personal Care Agency
28.	Total Charge	M	
29.	Amount Paid	C	If claim was billed to other insurance (including Medicare), attach explanation of benefits (EOB) indicating paid amount.
30.	Reserved for NUCC Use	B	
31.	Signature of Physician or Supplier Including Degrees or Credentials	M	
32.	Service Facility Location Information	M	ZIP+4 is required.
32a.	NPI# [Service Location]	O	
32b.	Other ID# [Service Location]	O	
33.	Billing Provider's Info & Ph #	M	Submitted info should match demographics on the Medicaid Provider Agreement.
33a.	NPI# [Billing Provider]	M*	*Atypical Providers: Leave blank
33b.	Other ID# [Billing Provider]	C	Atypical Providers: Enter qualifier G2 and billing provider's Medicaid Contract ID. Typical (NPI) Providers: Alaska Medicaid strongly recommends indicating the billing provider's taxonomy using qualifier ZZ.