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CMS-1500 Claim Form Instructions

Revised - See 09/24/2015 Version

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
- 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

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SAMPLE

HEALTH INSURANCE CLAIM FORM

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

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CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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 F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES 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? YES NO *If yes*, complete items 9, 9a, and 9d.

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

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. 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

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

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

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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	C	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). **Exception:** If an approved **TPL avoidance** record applies to the services billed, **leave blank**.
9a	Other Insured's Policy or Group #	C	
9b	Reserved for NUCC Use	B	
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	
10b	Is Patient's Condition Related to Auto Accident?	M	
10c	Is Patient's Condition Related to Other Accident?	M	

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Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
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.
17b.	NPI #		
18.	Hospitalization Dates Related to Current Services	B	

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	Claim Field Identification	M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
19.	Additional Claim Information (Designated by NUCC)	O	
20.	Outside Lab? $ Charges	B	
21.	Diagnosis or Nature of Illness or Injury	M	Required of all provider types. Enter the ICD indicator appropriate for the date of service. Alaska Medicaid will not accept ICD-10 qualifier/codes until 10/01/2015. Alaska Medicaid recommends the following providers use the following diagnosis codes indicated when a documented diagnosis is not known. Behavioral Rehabilitation .... V606 Care Coordination Agency.................................. 78099 Environmental Modification................................. V601 Home and Community-Based Agency................. 78099 Hotel .... V630 Personal Care Agency.. 7999 Pre-Maternal Home .... V222 Residential Supported Living .... V606 School-Based Services....................................... 78099 Taxi.. V630
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**.
	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. 1. N4 qualifier 2. 11-digit NDC number, 3. NDC unit of measure, and 4. NDC units administered. Example: N4XXXXXXXXXXXML1.0

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Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
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.ncpdp.org/standards/standards-quic-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 appropriate qualifier. **Atypical Providers:** Enter qualifier G2 in the **shaded** area.
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 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.

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	Claim Field Identification	M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
27.	Accept Assignment?	M*	*Required of all providers except the following, which should leave field **blank**: • 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]	M	**Typical (NPI) Providers:** Enter the appropriate qualifier and billing provider's taxonomy. **Atypical Providers:** Enter the appropriate qualifier and billing provider's Medicaid Contract ID.