Instructions on how to fill out the CMS 1500 Form

Item	Instructions
Item 1	***Type of Health Insurance Coverage Applicable to the Claim*** Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.
Item 1a	***Insured's ID Number*** ***(Patient's Medicare Health Insurance Claim Number - HICN)*** **This is a required field.** Enter the patient's Medicare HICN whether Medicare is the primary or the secondary payer. *Be sure to include the suffix and do not use spaces and/or dashes. (Example of proper HICN submission: 123456789A) An invalid HICN will cause a claim to deny or be rejected as unprocessable.* *If a patient's HICN begins with an alpha character, their claims must be filed to Railroad Medicare. The address is indicated here.* *Palmetto Government Benefits Administration* *PO BOX 10066* *Augusta GA 30999* ***Note:*** *Noridian Administrative Services (NAS) is prohibited from forwarding such claims.*
Item 2	***Patient's Name*** **This is a required field**. Enter the patient's last name, first name, and middle initial, if any, as it appears on the patient's Medicare card *(e.g., Jones John J). Include only one space between the last name, first name, and middle initial. If the name is not an identical match, the claim will be rejected as unprocessable.* *Do not submit extra spaces, nicknames, or descriptions such as Jr., Sr., deceased, or the estate of (unless indicated on the Medicare card). Do not extend the beneficiary's name beyond the confines of this box.*
Item 3	***Patient's Birth Date and Sex*** Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex. *Only one box should be indicated; either M or F. Marking both or neither will cause the claim to be rejected as unprocessable.*
Item 4	***Insured's Name*** **If Medicare is primary, leave blank**. If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME.
Item 5	***Patient's Address and Telephone Number*** **This is a required field and must be filled in completely.** Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and

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telephone number.

Patient's Relationship to Insured

Item 6 **If Medicare is primary, leave blank.** Check the appropriate box for *the* patient's relationship to *the* insured when item 4 is completed.

Insurance Primary to Medicare, Insured's Address and Telephone Number

Item 7 **Complete this item only when items 4, 6, and 11 are completed.** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME.

Patient's Marital Status and Whether Employed or a Student

Item 8 Check the appropriate box for the patient's marital status and whether employed or a student.

Medigap Benefits, Other Insured's Name

If no Medigap benefits are assigned, leave blank. Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. This field may be used in the future for supplemental insurance plans.

NOTE: Only Participating Physicians and Suppliers are to complete item 9 and its subdivisions and only when the Beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the Participating Physician or Supplier.

Item 9

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See chapter 28 *of the Medicare Claims Processing Manual.*)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or

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former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a

Medigap Benefits, Other Insured's Policy or Group Number
If no Medigap benefits are assigned, leave blank. Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP. *Do not enter other types of insurance (e.g., supplemental).*

NOTE: Item 9d must be completed if the provider enters a policy and/or group number in item 9a.

Item 9b

Medigap Benefits, Other Insured's Date of Birth
Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Item 9c

Medigap Benefits, Employer's/School Name
If a Medigap PayerID is entered in item 9d, leave blank. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code and ZIP code copied from the Medigap insured's Medigap identification card. For example:
1257 Anywhere Street
Baltimore MD 21204
is shown as: 1257 Anywhere St. MD 21204

Medigap Benefits, Insurance Plan/Program Name, PAYERID Number
Enter the nine-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

Item 9d

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

NOTE*: The configuration of the PAYERID is alpha numeric and up to 9 digits.* ***NAS assigns five digit alpha numeric or numeric PAYERID numbers rather than nine digit numbers.***

Items 10a–10c

Condition Relationship? Employment, Auto Liability, or Other Accident
Check "YES" or "NO" *by placing an (X) in the center of the box* to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES," indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11**.**

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Item 10d ***Leave blank. Not required by NAS.***

Insured's Policy Group or FECA Number

Note: *All claims can be submitted electronically. For more information pleaser refer to the EDISS web site.*

THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare *for the service date(s)*, enter the insured's policy or group number *within the confines of the box* and proceed to items 11a–11c. Items 4, 6, and 7 must also be completed. ***If item 11 is left blank, the claim will be denied as unprocessable.***

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, *do not enter "n/a," "not," etc.*, enter the word NONE *within the confines of the box* and proceed to item 12.

Item 11 If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word NONE and proceed to item 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word *NONE* in *item* 11 of *the CMS-1500 Form,* when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare - Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
  - Working Aged *(Type 12)*;
  - Disability (Large Group Health Plan – *Type 43*); and
  - End Stage Renal Disease *(ESRD – Type 13)*;
- No Fault *(Type 14)* and/or Other Liability *(Type 47)*; and
- Work-Related Illness/Injury:

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- Workers' Compensation *(Type 15)*;
- Black Lung *(Type 41)*; and
- Veterans Benefits *(Type 42).*

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, *a policy or group number must be entered in this item. In addition, a* copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Medicare Secondary Payer Manual, Chapter 3.) *Without an attached EOB from the primary insurance, the claim will be denied.*

Item 11a

Insured's Date of Birth and Sex

This item must be completed if a policy or group number is reported in item 11 AND is different from the date in item 3. Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b

Insurance Primary to Medicare, Employer's Name

This item must be completed if a policy or group number is submitted in item 11. Enter *the* employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word RETIRED. *Please add the employer's address and telephone number to the attached copy of the EOB.*

Item 11c

Insurance Plan/Program Name

This item must be completed if a policy or group number is submitted in item 11. Enter the nine-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. *Please include the telephone number of the primary payer.* This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d **Leave blank. Not required by Medicare.**

Item 12

Patient's or Authorized Person's Signature

The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alphanumeric date (e.g., January 1, *2006*) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements" may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless *the* patient or the patient's representative revokes this arrangement.

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NOTE: This can be Signature on File and/or a computer generated signature.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Medigap Benefits, Insured's/Authorized Person's Signature

Item 13

The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

NOTE: This can be Signature on File and/or a computer generated signature.

Date of Current Illness/Injury/Pregnancy

Item 14

- For **current illness, injury, or pregnancy**, enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date.
- For **chiropractic services**, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date *of x-ray (if used to demonstrate subluxation)* in item 19.

Item 15 **Leave blank. Not required by Medicare.**

Dates Patient Unable to Work in Current Occupation

Item 16

If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when *the* patient is unable to work.

An entry in this field may indicate employment related insurance coverage.

Name of the Referring or Ordering Physician

Item 17

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. *Use the physician's last name and as much of the first name as will fit in item 17. Do not use "self," "friend," etc.*

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

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1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;
4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or
5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15, for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by Section 1833(q) of the *Social Security* Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the

submission of the referring/ordering provider information:

- Medicare covered services and items that result from *a* physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner.

Do not extend the name beyond the confines of this box*. Only enter what will fit into item 17. Do not run the name into item 17a or 17b.*

UPIN of the Referring/Ordering Physician

Enter the ID Qualifier 1G *in the smaller box and* the CMS assigned UPIN of the referring/ordering physician listed in item 17 *in the larger box. The 1G and UPIN must be submitted within the confines of the appropriate boxes.* The UPIN may be reported on the *CMS-1500 Form* until May 22, 2007, and MUST be reported if an NPI is not available. *An invalid UPIN format will cause the claim to be rejected as unprocessable.*

Item 17a

Attention Providers: Effective immediately providers should include both the UPIN and the NPI of the referring physician. For claims received after July 2, 2007, providers may enter only the NPI number of the referring physician.

NOTE: CMS has announced that it is implementing a contingency plan for all covered entities that will not meet the May 23, 2007 deadline for NPI. For a complete overview of the CMS Contingency plan and related information, visit: http://www.cms.hhs.gov/nationalprovidentstand/

NOTE: Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

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When a claim involves multiple referring and/or ordering physicians, a separate *CMS-1500 Form* shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.

NPI of the Referring/Ordering Physician

Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. *The NPI must be entered within the confines of the larger box.* The NPI may be reported on the *CMS-1500 Form* (08-05) as early as January 1, 2007. *An invalid NPI will cause the claim to be rejected as unprocessable.*

Item 17b

NOTE: Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

NOTE: CMS has announced that it is implementing a contingency plan for all covered entities that will not meet the May 23, 2007 deadline for NPI. For a complete overview of the CMS Contingency plan and related information, visit: http://www.cms.hhs.gov/nationalprovidentstand/

Service Furnished as a Result of, or Subsequent to, a Related Hospitalization

Item 18

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Narrative Field

This is a required field for the purposes outlined below.

- Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date *the* patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

Item 19

- For physical therapy, occupational therapy, and speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are **not** required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. **However**, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to

policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see item 17 and 17a *and/or 17b*, and for the identification of the supervisor, see item *24J* of this section.

- Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the sublaxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of sublaxation) of Pub. 100-02, Medicare Benefits Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.
- Enter the drug's name, *strength,* and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.
- Enter a concise description of an "unlisted procedure code" or a "*not otherwise classified*" (NOC) code within the confines of this box. An attachment *may also need to be submitted to help expedite claim processing. If more than one unlisted procedure code is reported on the claim, precede each description in item 19 with the line item number that corresponds to the line that contains the NOC code. This will enable claims processing staff to determine the correct description for each unlisted procedure code. If billing the same unlisted procedure code more than once on the claim, you may need to indicate the charges of the procedure codes to indicate which description belongs to each line.*
- Enter all applicable modifiers when modifier 99 (multiple modifiers) is entered in item 24D. If modifier 99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a 99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item. ***Modifier 99 is only appropriate when more than four modifiers are necessary per claim line. When four or less modifiers apply, each modifier can be entered in the existing space in item 24D on the CMS-1500 Form.***
- Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound

or an institutional patient.)

- Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating provider/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.
- Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.
- When dental examinations are billed, enter the specific surgery for which the exam is being performed.
- Enter the specific name and dosage amount when low osmolar contrast material is billed, but **only if HCPCS codes do not cover them**.
- Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers **share postoperative care.**
- Enter demonstration ID number "30" for all national emphysema treatment trial claims.
- Enter the PIN (or NPI when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, Chapter 1, Section 30.2.9.1 for additional information.)
- Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis (See Pub. 100-04, Chapter 8, Section 60.7.2).
- *If a provider is enrolled in the Competitive Acquisition Program (CAP) for Medicare Part B Drugs and Biologicals, the prescription order number (RX order #) must be reported in item 19 on the CMS-1500 Form.*
- *For ambulance suppliers, the originating site information will be entered in item 32. It is recommended that providers list both the origin and destination information in item 32. If both the origin and destination do not fit within the confines of item 32, bill the origin in item 32 and the destination information in item 19. List the name of the facility, city, state, and ZIP code. The street address is not required. When transport is beyond the "closest facility", providers are to briefly identify why within the confines of item 19.*

Diagnostic and Purchased Tests

This is a required field when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked.

Item 20

- A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test.
- A "no" check indicates "no purchased tests are included on the claim."

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When "yes" is annotated, item 32 *must* be completed. **When billing for multiple purchased diagnostic tests, each test *must* be submitted on a separate *CMS-1500 Form.***

Patient's Diagnosis/Condition

Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) *must* use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for non-physician specialties shall be submitted on an attachment.

***NOTE:** Although ambulance suppliers are not required to submit ICD-9 codes on the claim, NAS highly encourages them to do so with the code that best describes the sign, symptom, and/or condition of the beneficiary at the time of transport.*

***Enter the diagnosis code only, not the description.** Any extraneous data in this field will cause an up front rejection of your claim. Do not use decimal points.*

Item 21

***NOTE:** You may place up to eight diagnosis codes on the claim form. The diagnosis that is pointed to in Item 24E must be placed in one of the first four diagnoses entry spaces in Item 21. Any indicator other than a 1, 2, 3, or 4 in Item 24E will cause the claim to deny as unprocessable. Place additional diagnosis codes 5-8 (if necessary) in Item 19. Enter only the number (with decimal if needed) and separate each diagnosis in Item 19 with a comma. [For example: 719.41, 719.42, 816.00]*

*The diagnosis codes listed in Item 19 **should not** be for codes that are **required** for payment, submit a second claim form with the **additional required codes** in Item 21. [For example: if CPT code "A" requires three diagnosis codes for payment and CPT "B" requires three different codes for payment, these two procedures would need to be billed on two separate claim forms so the processing system could pick up all six of the diagnosis codes as payable.]*

Item 22 **Leave blank. Not required by Medicare**

Prior Authorization Number

This is a required field for the purposes outlined below.

Item 23

- Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.
- Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

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- Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.
- ***Enter the ZIP code for the point of pickup for ambulance claims.*** *Because the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup are located in the same ZIP code. However, suppliers must prepare a separate claim form for each trip if the points of pickup are located in different ZIP codes. A claim without a ZIP code or with multiple ZIP codes will be denied as unprocessable.*

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate *CMS-1500 Form.*

Service Line

Item 24 The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. **At this time, the shaded area in 24*A* through 24*H* is not used by Medicare.** Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

Date of Service

Item 24A **This is a required field.** Enter a 6-digit *(MMDDYY)* or 8-digit (MMDDCCYY) date for each procedure, service, or supply *within the confines of this box.* When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

When billing a date span, it must be for consecutive days. If it is not, then bill each service separately. Days billed should correspond with the number of units in column G. If days span over a month, bill the services for each month on separate lines. Do not use quotation marks to indicate the date of service is the same as the line above. A date must be reported in this item.

Place of Service

Item 24B **This is a required field.** Enter the appropriate *2-digit* place of service code(s) from the list provided in Section 10.5 *of the Medicare Claims Processing Manual, Chapter 26.* Identify the location, using a place of service code, for each item used or service performed.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient

hospital" code.

Enter only one place of service code per CMS-1500 Form, unless the second place of service code is 12 (patient's home).

Item 24C **Leave blank. Not required by Medicare.**

Procedures, Services, or Supplies Code

This is a required field. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The *CMS-1500 Form* has the ability to capture up to four modifiers.

Enter the specific procedure code **without** a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment *must* be submitted with the claim.

Item 24D

Return as unprocessable if an "unlisted procedure code" or *a "not otherwise classified"* (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment.

Modifiers must be two alpha/numeric characters. Do not place extra narrative after, under, or above the procedure code. Pricing modifiers should be placed in the first modifier position. Procedure codes should not be placed in the first modifier position. Be sure to distinguish between zeros and the letter "O". Hyphens or any other separators should not be used between procedure codes and modifiers. ***Only uppercase characters should be used for procedure codes and modifiers.***

Diagnosis Code Reference Number

This is a required field. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. **Enter only one reference number per line item.** When multiple services are performed, enter the primary reference number for each service, **either a 1, or a 2, or a 3, or a 4**. *Entering anything other than a 1, or a 2, or a 3, or a 4 will cause the claim to be rejected as unprocessable,*

Item 24E

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), **the provider shall reference only one** of the diagnoses in item 21.

Place only a single diagnosis pointer on each line. Do not enter the ICD-9 code(s) and/or diagnosis narratives in this item. The NAS processing system is capable of referencing all diagnosis codes in item 21 as needed.

Item 24F ***Enter the charge for each listed service***

Instructions on how to fill out the CMS 1500 Form

Enter the charge for each listed service. *Include the cents with dollar amounts. For example, $24.00 must be entered as 2400 rather than 24 or 24-. Do not use dollar signs, decimals, dashes, commas, or lines. Negative dollar amounts are not allowed.*

Note: *Competitive Acquisition Program (CAP) physicians should enter a billed amount for each CAP drug. Do not enter a zero dollar amount.*

Days or Units

Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 **must** be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24*G*. Convert hours into minutes and enter the total minutes required for this procedure *(e.g., 2*

Item 24G *hours and 10 minutes would be reported as 130. One hour and 10 minutes would be reported as 70).*

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of the *Medicate Claims Processing Manual.*

Do not place zeros before or after the number of units (e.g., a service of 1 should ***not*** *be billed as 010; it should be billed as 1. Indicate only whole numbers, e.g., do* ***not*** *bill 1.5).*

NOTE: This field should contain at least 1 day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H **Leave blank. Not required by Medicare.** *Entering information in this item may cause delays in claims processing.*

ID Qualifier

Item 24I Enter the ID qualifier **1C** in the shaded portion *when submitting the rendering physician's PIN in 24J.*

PIN/NPI of the Rendering Provider

Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician

Item 24J or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion. *Do not enter PIN numbers with the alpha state code indicator, before the PIN number. The addition of this indicator will cause the claim to be rejected as unprocessable.*

Instructions on how to fill out the CMS 1500 Form

For example, a North Dakota PIN would be entered as 000, not N000.

Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than January 1, 2007, enter the rendering provider's NPI number in the lower *non-shaded* portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower *non-shaded* portion. *An invalid NPI will cause the claim to be rejected as unprocessable.*

Attention Providers:

Billing and Placement of the NPI and Legacy Numbers on the Revised CMS-1500 (08-05) Claim Form

1. ***An incorporated Solo Provider*** *with one Legacy Provider Identification Number (PIN) and both an Individual National Provider identifier (NPI) number and a Group NPI number, must bill as follows:*
    - *Individual NPI number in 33a*
    - *Leave Item 24J blank (Rendering Physician NPI number)*

    Note: *Claims will reject if the Group/Organization NPI number is used in Item 33a. The claims processing system has no Group/Organization Legacy PIN number to which to cross-reference the NPI number at this time.*

    At some point, an incorporated solo provider with only an Individual Legacy PIN and NPI number may receive both a Group Legacy PIN and a Group NPI number. This will happen if any provider file changes are made through the NAS Enrollment Department (e.g. Tax ID, address, etc.). If and when this occurs, the provider will then bill as a group.

2. ***An Incorporated Solo Provider*** *with an Individual Legacy PIN and a Group Legacy PIN, as well as an Individual NPI and a Group NPI, must bill as following:*
    - *Group/Organization NPI number in Item 33a and*
    - *Individual/Rendering provider NPI in Item 24J*
3. ***Clinics and multiple group offices****, must bill as following:*
    - *Group/Organization NPI number in Item 33a and*
    - *Individual/Rendering provider NPI in Item 24J*
4. ***Solo/Individual provider NOT incorporated****, must bill as following:*
    - *NPI in 33a and*
    - *Leave 24J blank*

Instructions on how to fill out the CMS 1500 Form

NOTE: CMS has announced that it is implementing a contingency plan for all covered entities that will not meet the May 23, 2007 deadline for NPI. For a complete overview of the CMS Contingency plan and related information, visit: http://www.cms.hhs.gov/nationalprovidentstand/

Information must be submitted within the confines of this box. *Be sure to distinguish between zeros and the letter "O". Do not enter provider names, UPIN numbers, or state postal codes in this item.*

Item 24K There is no item 24K on this version.

Provider or Supplier Federal Tax ID (Employer Identification Number)

Item 25 Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. *Enter an (X) in the appropriate box to indicate which number is being reported. Only one box can be marked.* ***Do not enter hyphens or spaces.*** Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Patient's Account Number

Item 26 **This field is optional** to assist the provider in patient identification. Enter the patient's account number assigned by the provider's of service or supplier's accounting system. As a service, any account numbers entered here will be returned to the provider. ***If an account number is entered in this item, it will appear on the provider remittance notice/advice.***

Accept Assignment?

This is a required field, even if you are a participating provider. Check the appropriate *box with an (X)* to indicate whether the provider of service or supplier accepts assignment of Medicare benefits *or not.* If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

Item 27

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists,

clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Total charges for services on claim

Item 28 Enter *the* total charges for the services (i.e., total of all charges in 24F). *Include the cents with dollar amounts. For example, $24.00 must be entered as 2400 rather than 24 or 24-. Do not use dollar signs, decimals, dashes, commas, or lines. Negative dollar amounts are not allowed. Do not mark as continued or the claim will be rejected as unprocessable;* ***each CMS-1500 Form should have its own total.***

Total amount the patient paid on the covered services only

Item 29 Enter the total amount the patient paid on the covered services only. *Include the cents with dollar amounts. For example, $24.00 must be entered as 2400 rather than 24 or 24-. Do not use dollar signs, decimals, dashes, commas, or lines. Negative dollar amounts are not allowed. Do not mark as continued or the claim will be rejected as unprocessable; each CMS-1500 Form should have its own total.*

Do not include the amount paid by the primary insurance, co-insurance, deductibles, account balance, or payments on previous claims in this item.

Note: *If any dollar amount is entered here, part or all of the payment will go directly to the patient,* ***even if you are a participating provider.***

Item 30 **Leave blank. Not required by Medicare.**

Signature of Provider of Service or Supplier

Item 31 **This is a required field.** Enter the signature of *the* provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, *2006*) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the

following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature. *NAS is unable to process claims without the required signature and date listed in item 31. If left blank, the claim will be rejected as unprocessable.*

The signature and date must be completely within the confines of this box. *Additional acceptable signatures include: Signature stamp and computer generated signature.*

Name and Address of Facility Where Services Were Rendered
Enter the name, address, and ZIP code of the facility if the services were furnished in a physician's office, hospital, clinic, laboratory, or facility other than the patient's home. Only one name, address, and ZIP code may be entered in the box. If additional entries are needed, separate claim forms shall be submitted.

Enter the name and address information in the following format:
1st Line – Name
2nd Line – Address
3rd Line – City, State Postal Code, and ZIP Code

Note: *Enter a complete address for the location where the services were performed. A PO Box is not acceptable. Do not include telephone numbers, commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between the city and the state postal code. When entering a 9-digit ZIP code, include the hyphen.*

Item 32

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate *CMS-1500 Form* shall be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. When more than one supplier is used, a separate *CMS-*

Instructions on how to fill out the CMS 1500 Form

1500 Form shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than *the patient's* home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Ambulance suppliers are required to submit both origination and destination information. The originating site information must be entered in item 32. It is recommended that providers list the name of the facility, city, state and ZIP code. The street address is not required. If there is not enough space for destination information in item 32, providers must enter this information in item 19. The origin and destination modifiers will identify the type of facility the beneficiary was transported to. When transport is beyond the "closest facility", providers are required to briefly identify why and that information is also placed in item 19.

Example:

32. SERVICE FACILITY LOCATION INFORMATION

TO: Hospitals Inc
Anytown IL 60610-6789
FROM: Physician Practice Inc
Anytown IL 60610-1234

a. *b.*

Item 32a

NPI of Service Facility
Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the *CMS-1500 Form* (08-05) as early as January 1, 2007, and must be reported May 23, 2007, and later.

NOTE: CMS has announced that it is implementing a contingency plan for all covered entities that will not meet the May 23, 2007 deadline for NPI. For a complete overview of the CMS Contingency plan and related information,

Instructions on how to fill out the CMS 1500 Form

visit: http://www.cms.hhs.gov/nationalprovidentstand/

Providers of service (namely physicians) shall identify the supplier's NPI when billing for purchased diagnostic tests.

Example:

32. SERVICE FACILITY LOCATION INFORMATION

Physician Practice Inc
1234 Healthcare Street
Anytown IL 60610-1234

a. 9876543210 b.

ID Qualifier and PIN
Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. **Effective May 23, 2007, and later, 32b is not to be reported.**

NOTE: CMS has announced that it is implementing a contingency plan for all covered entities that will not meet the May 23, 2007 deadline for NPI. For a complete overview of the CMS Contingency plan and related information,
Item 32b ***visit: http://www.cms.hhs.gov/nationalprovidentstand/***

Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests.

For durable medical, orthotic, and prosthetic claims, enter the PIN (of the location where the order was accepted) if the name and address was not provided in item 32 (DMERC only).

Provider's/ Supplier's Telephone Number, Billing Name, Address, and ZIP Code.
This is a required field. Enter the provider of service/supplier's *telephone number*, billing name, address, *and* ZIP code.

Item 33

Enter the name and address information in the following format:
1st Line – Name
2nd Line – Address
3rd Line – City, State Postal Code, and ZIP Code

NPI of Billing Provider or Group
This is a required field. Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the
Item 33a *CMS-1500 Form* (08-05) as early as January 1, 2007.

Attention Providers:

Instructions on how to fill out the CMS 1500 Form

Billing and Placement of the NPI and Legacy Numbers on the Revised CMS-1500 (08-05) Claim Form

1. ***An incorporated Solo Provider*** *with one Legacy Provider Identification Number (PIN) and both an Individual National Provider identifier (NPI) number and a Group NPI number, must bill as follows:*
    - *Individual NPI number in 33a*
    - *Leave Item 24J blank (Rendering Physician NPI number)*

    Note: *Claims will reject if the Group/Organization NPI number is used in Item 33a. The claims processing system has no Group/Organization Legacy PIN number to which to cross-reference the NPI number at this time.*

    At some point, an incorporated solo provider with only an Individual Legacy PIN and NPI number may receive both a Group Legacy PIN and a Group NPI number. This will happen if any provider file changes are made through the NAS Enrollment Department (e.g. Tax ID, address, etc.). If and when this occurs, the provider will then bill as a group.

2. ***An Incorporated Solo Provider*** *with an Individual Legacy PIN and a Group Legacy PIN, as well as an Individual NPI and a Group NPI, must bill as following:*
    - *Group/Organization NPI number in Item 33a and*
    - *Individual/Rendering provider NPI in Item 24J*
3. ***Clinics and multiple group offices****, must bill as following:*
    - *Group/Organization NPI number in Item 33a and*
    - *Individual/Rendering provider NPI in Item 24J*
4. ***Solo/Individual provider NOT incorporated****, must bill as following:*
    - *NPI in 33a and*
    - *Leave 24J blank*

NOTE: CMS has announced that it is implementing a contingency plan for all covered entities that will not meet the May 23, 2007 deadline for NPI. For a complete overview of the CMS Contingency plan and related information, visit: http://www.cms.hhs.gov/nationalprovidentstand/

Example:

33. BILLING PROVIDER INFO & PH# (312) 555 2222

Physician Practice Inc
1234 Healthcare Street
Anytown IL 60610-1234

Instructions on how to fill out the CMS 1500 Form

a. 9876543210 b.

Note: *Submitting an invalid NPI in this item will cause the claim to be rejected as unprocessable.*

ID Qualifier and PIN

Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. **Effective May 23, 2007, and later, 33b is not to be reported.** Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

Attention Providers:

Billing and Placement of the NPI and Legacy Numbers on the Revised CMS-1500 (08-05) Claim Form

1. ***An incorporated Solo Provider*** *with one Legacy Provider Identification Number (PIN) and both an Individual National Provider identifier (NPI) number and a Group NPI number, must bill as follows:*
    - *Individual NPI number in 33a*
    - *Leave Item 24J blank (Rendering Physician NPI number)*

Note: *Claims will reject if the Group/Organization NPI number is used in Item 33a. The claims processing system has no Group/Organization* **Item 33b** *Legacy PIN number to which to cross-reference the NPI number at this time.*

At some point, an incorporated solo provider with only an Individual Legacy PIN and NPI number may receive both a Group Legacy PIN and a Group NPI number. This will happen if any provider file changes are made through the NAS Enrollment Department (e.g. Tax ID, address, etc.). If and when this occurs, the provider will then bill as a group.

2. ***An Incorporated Solo Provider*** *with an Individual Legacy PIN and a Group Legacy PIN, as well as an Individual NPI and a Group NPI, must bill as following:*
    - *Group/Organization NPI number in Item 33a and*
    - *Individual/Rendering provider NPI in Item 24J*
3. ***Clinics and multiple group offices****, must bill as following:*
    - *Group/Organization NPI number in Item 33a and*
    - *Individual/Rendering provider NPI in Item 24J*
4. ***Solo/Individual provider NOT incorporated****, must bill as following:*
    - *NPI in 33a and*

Instructions on how to fill out the CMS 1500 Form

- *Leave 24J blank*

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

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? PLACE (State) ☐ YES ☑ NO

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES 0

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. 0

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		/1			/1	POS	emg	cpt	odifier odifie odifier odifier	gnosisPoir	charges	1		NPI	rendering Provider 2 rendering Provider 1
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)

Clear Form

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.
