CMS – 1500 Claim Form

This guide is designed to be used as a reference tool to identify and provide a description of each field on the new CMS 1500 Claim Form. This form replaces the old CMS 1500 form; please note that the new CMS 1500 form includes a field location for both **individual and group NPI submission**. The CMS - 1500 claim form must be completed for all professional medical services. All claims must be submitted within the required filing timeframe. More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

CMS 1500 Claim Form

The new CMS-1500 form replaces the old CMS-1500 form, which now includes a field location for both individual and group NPI submission. The CMS-1500 claim form must be completed for all professional medical services. All claims must be submitted within the required filing time line.

Centene will be accepting both NPI and legacy ID numbers beginning May 1, 2007 and targeting July 1, 2007 for NPI only.*

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1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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 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. PATIENT STATUS Single Married Other — CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( ) — Employed Full-Time Student Part-Time Student — ZIP CODE TELEPHONE (Include Area Code) ( )

FORMATION

FIELD #	FIELD DESCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other.	Not Required
1a	INSURED Program Identification	Health Plan's member identification number. Normally member's MEDCAID ID number.	Required
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Health Plan I.D. card.	Required
3	PATIENT'S DATE OF BIRTH / SEX	MMDDYY/ M or F	Required
4	INSURED's NAME	Enter the patient's name as it appears on the member's Health Plan I.D. card.	Required
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	Required
6	PATIENT's Relation to Insured	Always indicate self.	Conditional
7	INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	Not Required
8	PATIENT's Status	Enter the patient's marital status, indicate if the patient is employed or is a student.	Not Required

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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) (9)

a. OTHER INSURED'S POLICY OR GROUP NUMBER (9a)

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F (9b)

c. EMPLOYER'S NAME OR SCHOOL NAME (9c)

d. INSURANCE PLAN NAME OR PROGRAM NAME (9d)

10. IS PATIENT'S CONDITION RELATED TO: (10)

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER (11)

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F (11a)

b. EMPLOYER'S NAME OR SCHOOL NAME (11b)

c. INSURANCE PLAN NAME OR PROGRAM NAME (11c)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (11d) YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INF

(12) **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. (13)

SIGNED ______

FIELD #	FIELD DESCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. **REQUIRED** if patient is covered by another insurance plan. Enter the complete name of the insured. **NOTE: COB claims that require attached EOBs must be submitted on paper.**	Conditional
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	**REQUIRED** if # 9 is completed	Conditional
9b	OTHER INSURED'S BIRTH DATE / SEX	**REQUIRED** if # 9 is completed. MMDDYY / M or F by check box	Conditional
9c	EMPLOYER'S NAME OR SCHOOL NAME	This field is related to the insured in field # 9.	Conditional
9d	INSURANCE PLAN NAME OR PROGRAM NAME	**REQUIRED if # 9 is completed.**	Conditional
10a, b, c	IS PATIENT'S CONDITION RELATED TO:	Indicate Yes or No for each category.	Required
10d	ACCIDENT STATE	Accident State	Not Required
11	INSURED'S POLICY GROUP OR FECA NUMBER	**REQUIRED** when other insurance is available.	Conditional
11a	INSURED'S BIRTH DATE / SEX	MMDDYY/ M or F	Conditional
11b	EMPLOYER'S NAME OR SCHOOL NAME	**REQUIRED** if employment is indicated in field # 10.	Conditional
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Enter name of Health Plan	Conditional
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Y or N by check box. If yes, complete # 9a-d and #11c.	Required
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Not Required
13	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Not Required

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14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (14)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY (15)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY (16)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17)

17a. (17a)

17b. NPI (17b)

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

19. RESERVED FOR LOCAL USE (19)

20. OUTSIDE LAB? YES NO — $ CHARGES (20)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) (21)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO. (22)

23. PRIOR AUTHORIZATION NUMBER (23)

FIELD #	FIELD DESCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	MMDDYY	Conditional
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	MMDDYY	Not Required
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	MMDDYY	Not Required
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**REQUIRED** if a provider other than the member's primary care physician rendered invoiced services.	Conditional
17a	ID NUMBER OF REFERRING PHYSICIAN	Enter the Medicaid ID number for the referring physician. **REQUIRED** if #17 is completed and NPI is not applicable. **NOTE: Enter any non-npi id number for referring provider. May be Medicaid or Plan Identifier (must use qualifier)**	Conditional
17b	NPI NUMBER OF REFERRING PHYSICIAN	Enter the NPI number for the Referring Physician. **REQUIRED** if applicable.	Conditional
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When place of service is in-patient. MMDDYY	Not Required
19	RESERVED FOR LOCAL USE	If applicable, this box should be used for beneficiaries participating in special programs (i.e., Medical Homes, PEP, Hospice, etc) when a referral number is issued by the primary care provider.	Not Required
20	OUTSIDE LAB CHARGES		Not Required
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)	**REQUIRED:** Diagnosis codes must be valid ICD-9 codes for the date of service. "E" codes are NOT acceptable as a primary diagnosis. **NOTE: Claims missing or with invalid diagnosis codes will be denied for payment.**	Required
22	MEDICAID RESUBMISSION CODE ORIGINAL REF.NO.	For re-submissions or adjustments, enter the DCN (Document Control Number) of the original claim. **NOTE: Re-submissions may NOT currently be submitted via EDI.**	Conditional

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Peach State Health Plan™

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CMS 1500 Claim Form

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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. #
24a	24b	24c	24d	24e	24f	24g	24h	24i NPI	24jb
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

FIELD #	FIELD DESCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
24a-h (shaded)	SUPPLEMENTAL INFORMATION	Shaded top portion of each service line to be used for reporting of supplemental information. (NDC, Anesthesia Start/Stop, etc.) Must be proceeded by a Qualifier ID. **NOTE: See Appendix for list of qualifiers.**	Conditional
24a	DATE(S) OF SERVICE	"From" date: MMDDYY. If the service was performed on one day there is no need to complete the "to" date.	Required
24b	PLACE OF SERVICE	Enter the CMS standard place of service code.	Required
24c	EMG	Must be Y or N	Required
24d	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	**REQUIRED:** Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. Claims missing or invalid will be denied for payment.	Required
24e	DIAGNOSIS CODE	**REQUIRED:** Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1,2,3, or 4). Diagnosis codes must be valid ICD-9 codes for the date of service.	Required
24f	CHARGES	Enter charges	Required
24g	DAYS OR UNITS	Enter quantity	Required
24h	EPSDT	Response codes in top shaded area. Un-shaded area must be either Y or N.	Conditional
24i	QUALIFIER CODE	ID Qualifier for 24Ja (shaded). **REQUIRED** if other Provider ID is submitted in 24Ja. **NOTE: See Appendix for a list of qualifiers.**	Conditional
24ja (shaded)	Non-NPI PROVIDER ID#	**Typical Providers:** May 1, 2007 –June 30, 2007: Enter the current Medicaid Provider ID Number. July 1, 2007 and after: May be Medicaid ID, Plan Identifier, or Taxonomy code. (must use qualifier in 24i) **Atypical Providers:** May 1, 2007 and after: Enter the appropriate Legacy Provider (Medicaid) ID Number. **NOTE : Enter any non-NPI ID number for rendering Provider. May be Medicaid or Plan Identifier (must use qualifier in 24i) REQUIRED** if NPI is blank. See Appendix for qualifier list.	Required
24jb	NPI PROVIDER ID	The rendering provider's individual 10-character NPI number should be entered here. (Even if billing as a part of a group) The rendering provider's individual NPI may be reported as early as May 1, 2007; it must be reported on and after June 30, 2007. **REQUIRED** if 24Ja is blank.	Required

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25. FEDERAL TAX I.D. NUMBER SSN EIN (25) | 26. PATIENT'S ACCOUNT NO. (26) | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO (27) | 28. TOTAL CHARGE $ (28) | 29. AMOUNT PAID $ (29) | 30. BALANCE DUE $ (30)

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.) (31) SIGNED DATE | 32. SERVICE FACILITY LOCATION INFORMATION (32) a. (32a) b. (32b) | 33. BILLING PROVIDER INFO & PH # ( ) (33) a. (33a) b. (33b)

FIELD #	FIELD DESCRIPTION	INSTRUCTIONS OR COMMENTS	REQUIRED OR CONDITIONAL
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Physician or Supplier's 9-digit Federal Tax ID numbers. Can not be blank or all "zeros."	Required
26	PATIENT'S ACCOUNT NUMBER	The provider's billing account number.	Conditional
27	ACCEPT ASSIGNMENT?	Always indicate Yes. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	Required
28	TOTAL CHARGES	**REQUIRED** if a provider other than the member's primary care physician rendered invoiced services.	Required
29	AMOUNT PAID	**REQUIRED** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	Conditional
30	BALANCE DUE	**REQUIRED** when #29 is completed.	
31	SIGNATURE/NAME OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	**REQUIRED:** Professional signature of rendering Provider. "Signature on File" or "SOF" is not acceptable.	Required
32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office).	**REQUIRED** unless #33 is the same information. Enter the physical location. (P.O. Box #'s are not acceptable here.)	Required
32a	NPI – SERVICES RENDERED	Enter the Rendering provider 10-character NPI number. The provider's NPI may be reported as early as May 1, 2007; it must be reported on and after July 1, 2007.	Not Required
32b	OTHER PROVIDER ID	**Typical Providers:** May 1, 2007 –June 30, 2007: Enter the current Medicaid Provider ID Number. July 1, 2007 and after: May be Medicaid ID, Plan Identifier, or Taxonomy code. (must use qualifier in 24i) **Atypical Providers:** May 1, 2007 and after: Enter the appropriate Legacy Provider (Medicaid) ID Number. N**OTE : Enter any non-NPI ID number for rendering Provider. May be Medicaid or Plan Identifier (must use qualifier in 24i) REQUIRED** if NPI is blank. See Appendix for qualifier list.	Required
33	PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # / NPI # / Other ID #	Enter the complete name and address of the provider. NPI #: Enter the Health Plan assigned group NPI ID. Other ID #: Enter the Health Plan assigned group provider ID or Medicaid assigned group number.	Required
33a	GROUP BILLING NPI	**NPI #:** Enter the Health Plan assigned group NPI ID. **REQUIRED** if 33b is blank. Effective July 1, 2007, you MUST enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member of a group, enter the 10-character individual NPI number in this box. The NPI may be reported as early as May 1, 2007.	Required
33b	GROUP BILLING OTHER ID	**Typical Providers:** May 1, 2007 –June 30, 2007: Enter the current Medicaid Provider ID Number. July 1, 2007 and after: May be Medicaid ID, Plan Identifier, or Taxonomy code. (must use qualifier in 24i) **Atypical Providers:** May 1, 2007 and after: Enter the appropriate Legacy Provider (Medicaid) ID Number. N**OTE : Enter any non-NPI ID number for rendering Provider. May be Medicaid or Plan Identifier (must use qualifier in 24i) REQUIRED** if NPI is blank. See Appendix for qualifier list.	Required

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Appendix

INSTRUCTIONS OF SUPPLEMENTAL INFORMATION FOR CMS-1500 FIELD 24a-h (shaded)

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

Anesthesia duration in hours and/or minutes with start and end times
Narrative description of unspecified codes
National Drug Codes (NDC) for drugs
Vendor Product Number – Health Industry Business Communications Council (HIBCC)
Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
Contract rate

The following qualifiers are to be used when reporting these services:

7	Anesthesia information
ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
VP	Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) CTR Contract rate

The following qualifiers are to be used when reporting NDC units:

F2	International Unit ML Milliliter
GR	Gram UN Unit

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

Appendix

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

PROVIDER QUALIFIER ID

Title: Alternate Provider Qualifier ID

Instructions: On the CMS-1500, this field was originally labeled "EMG". However, "EMG" is now located in 24C. Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. On the UB04, it is used as a prefix for alternate ID's in field 57a, b, and c. The Other ID# of the rendering provider is reported in 24J in the shaded area. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:

0B	State License Number
1B	Blue Shield Number
1C	Medicare Provider Number
1D	Medicaid Provider Number
1G	Provider UPIN Number
1H	Champus Identification Number
EI	Employer's Identification Number
G2	Provider Commercial Number
LU	Location Number
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may be used for Medicare)
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. These qualifiers would apply to the Billing Provider (33 on CMS-1500) or Attending/Operating Provider (76-79 UB04).

Description: If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.

Field Specification: This field allows for the entry of a 2 character qualifier in the shaded area.