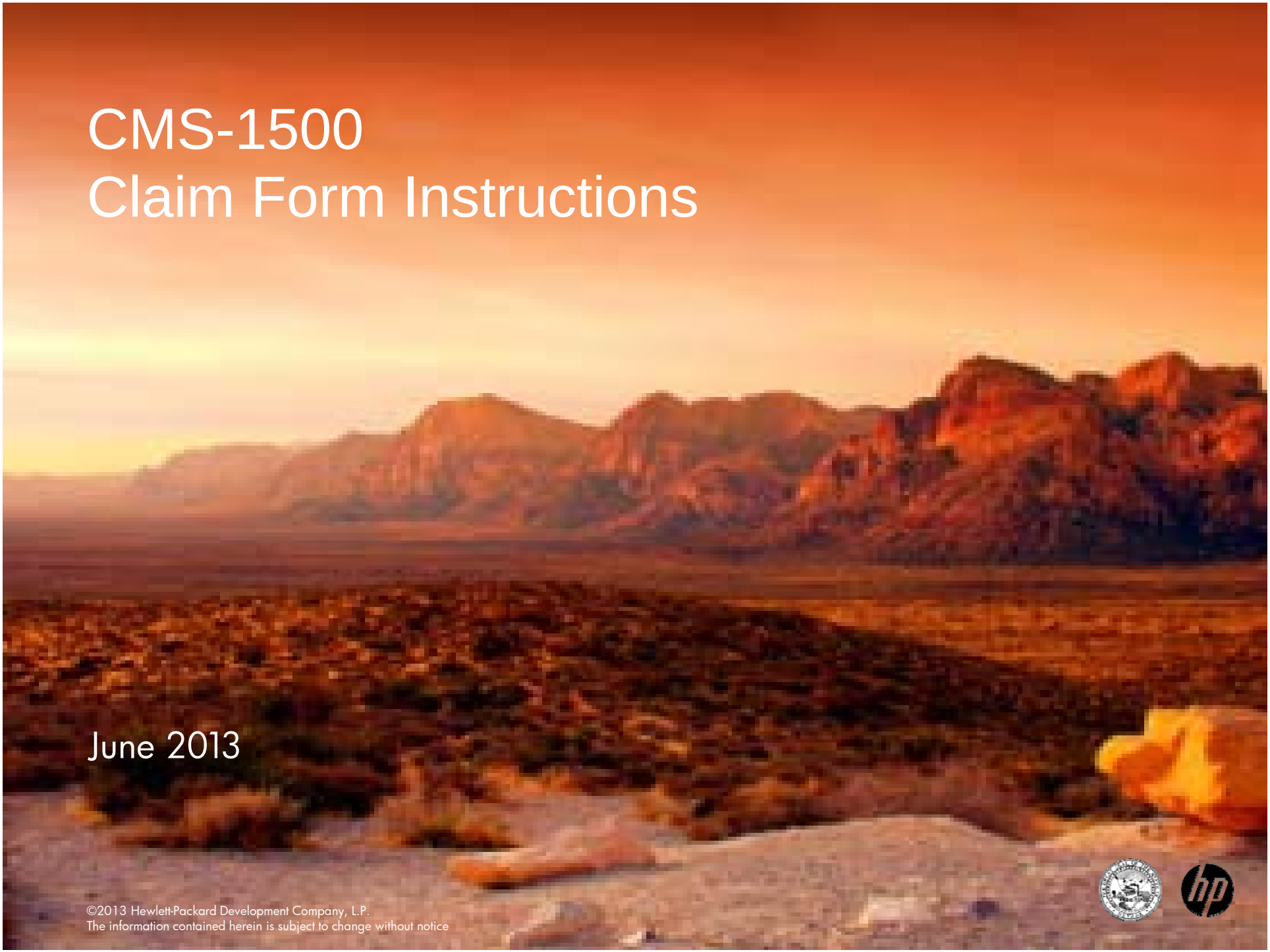
# CMS-1500
# Claim Form Instructions



June 2013

# Topics

- Field requirements
- Voiding a claim
- Adjusting a claim
- Field requirement table
- Claims mailing address

# Introduction

- These instructions address Nevada Medicaid *paper* claim requirements. If you submit electronic claims through a clearinghouse, please contact the clearinghouse directly if you have a question specific to submitting a claim or receiving an electronic remittance advice.

- To register to submit electronic claims to Medicaid, see the "Electronic Claims/EDI" webpage online at http://www.medicaid.nv.gov. The EDI webpage contains EDI enrollment forms, announcements and companion guides.

# Field Requirements

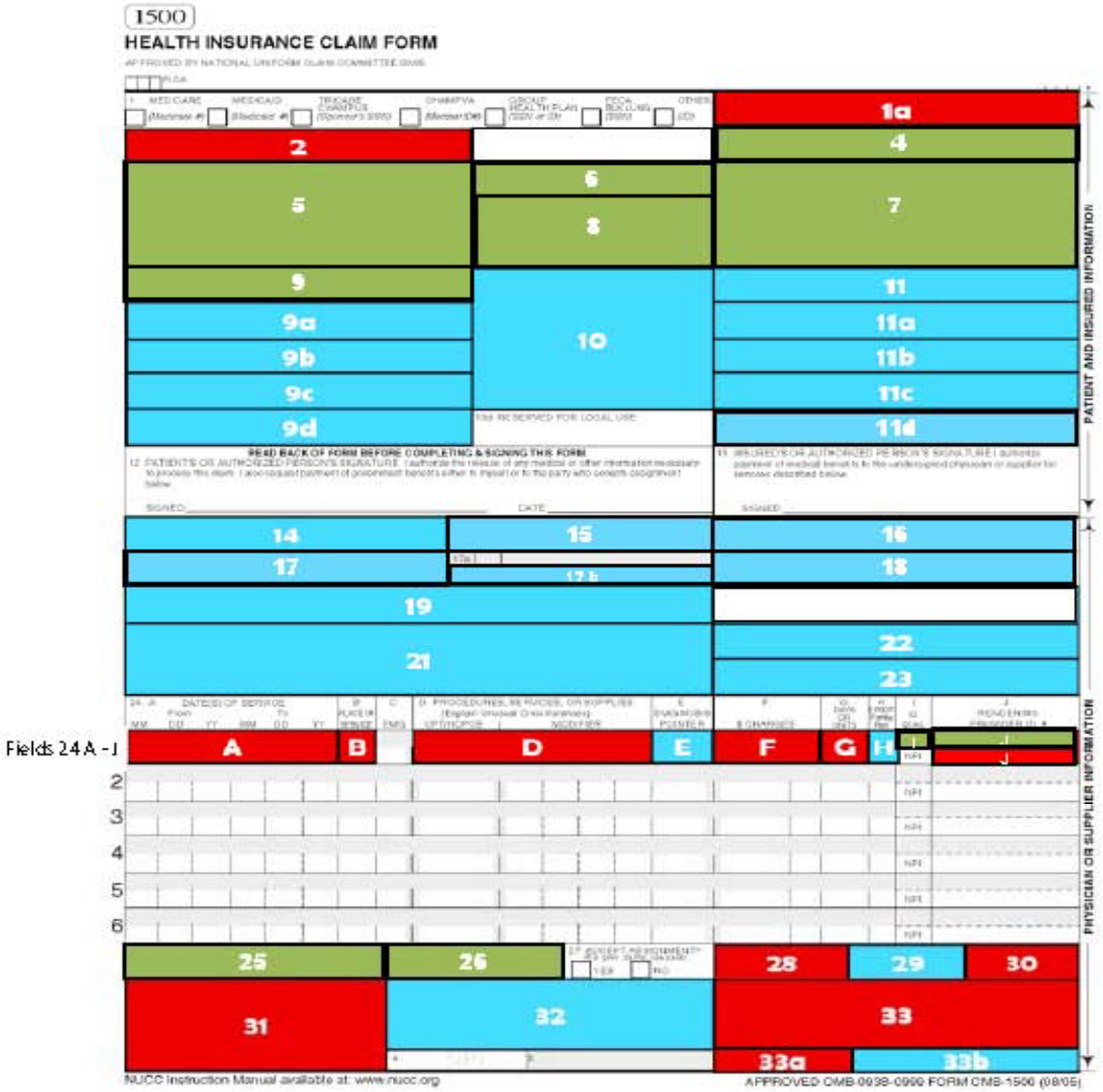
*Required* - Fields marked *Required* in the CMS-1500 claim form instructions are required on all paper claim submissions. The claim may be denied or returned if a *required* field is incomplete. For example, the recipient's 11-digit Recipient ID (Enrollee ID) as shown on their Medicaid card must be entered in Field 1a.

*Situational* - Fields marked *Situational* are required when they apply to the claim. For example, Field 9a (marked Situational) must be populated with the policy or group number only when Third Party Liability (TPL) applies.

*Recommended* - Fields marked *Recommended* are not required, but will be returned with the provider's remittance advice if supplied on the claim. For example, if the provider's in-house, patient account number is provided in Field 26, it will be returned on the remittance advice thereby allowing billing staff to cross reference the claim with the provider's records if needed.

*Not Required* - Fields marked *Not Required* are not used in processing the claim, although the provider is free to populate the field if desired. For example, providers may use Field 3 to enter the recipient's birth date and sex, but the data will not be used to adjudicate the claim.

# CMS-1500 Claim Form Color Guide



# Voiding A Claim

- A claim void may be submitted when a previously *paid* claim should not have paid. The reversal of the claim will appear on the remittance advice.
- To void a claim, complete the following claim form fields:
  - Field 22: Include the most appropriate void reason code from the table.
  - In the Original Reference Number area, enter the last paid Internal Control Number (ICN) of the claim.


- Adjustments and voids apply to previously paid claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment.

# Void Codes

| Code | Description |
|---|---|
| 1044 | Wrong provider identifier used |
| 1045 | Wrong Recipient ID used |
| 1047 | Duplicate payment |
| 1048 | Primary carrier has paid full charges |
| 1052 | Miscellaneous |
| 1060 | Other insurance is available |

# Adjusting A Claim

- A claim adjustment may be submitted to modify a previously *paid* claim. Timely filing limits apply.
- To adjust a claim, complete the following claim form fields:
  - Field 22: Include the most appropriate void reason code from the table.
  - In the Original Reference Number area, enter the last paid Internal Control Number (ICN) of the claim.


- Adjustments and voids apply to previously paid claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment.

# Adjustment Codes

| Code | Definition |
|---|---|
| 1021 | Late charges received by facility business office |
| 1023 | Primary carrier has made additional payment |
| 1028 | Correcting procedure/service code |
| 1029 | Correcting diagnosis code |
| 1030 | Correcting charges |
| 1031 | Correcting units, visits or studies |
| 1034 | Correcting quantity dispensed |
| 1035 | Correcting drug code |
| 1041 | Incorrect amount paid for original claim |
| 1042 | Original claim has multiple incorrect items |
| 1053 | Adjustment (miscellaneous) |

# Instructions For Completing The CMS-1500 Form

| Field | Requirement | Field Name and Instructions for CMS-1500 (08/05) Claim Form |
|---|---|---|
| 1 | Not required | Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other |
| **1a** | **Required** | **Insured's ID number:** Enter the recipient's 11-digit Recipient ID (Enrollee ID) as shown on their Medicaid card. |
| **2** | **Required** | **Patient's name:** Enter recipient's full last name, first name and middle initial as indicated on the Medicaid ID card. |
| 3 | Not Required | Patient's birth date, sex: Enter the recipient's birth date in MM DD CCYY format. Enter an X in the correct box to indicate the recipient's gender. |
| 4 | Recommended | Insured's name |
| 5 | Recommended | Patient's Address, City, State, Zip Code, Telephone |
| 6 | Recommended | Patient relationship to insured |
| 7 | Recommended | Insured's Address, City, State, Zip Code, Telephone |
| 8 | Recommended | Patient status |
| 9 | Recommended | Other insured's name |
| **9a** | **Situational** | **Other insured's policy or group number:**<br>*Recipient has TPL with **Medicare** coverage:* Enter the recipient's Medicare number.<br>*Recipient has TPL with **commercial** coverage:* Enter the recipient's identifier with their primary carrier. |
| 9b | Situational | Other insured's date of birth, sex |
| 9c | Situational | Employer's name or school name |
| **9d** | **Situational** | **Insurance plan name or program name:**<br>*Recipient has **Medicare** coverage:* Enter the word *Medicare* followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus).<br>*Recipient has TPL with **commercial** coverage:* Enter the name of the primary carrier. |
| **10a-c** | **Situational** | **Is patient's condition related to:** If the recipient's condition is a result of a work-related circumstance/occurrence, an automobile accident or other type of accident, check *YES* on the appropriate line. |

# Instructions For Completing The CMS-1500 Form

| Field | Requirement | Field Name and Instructions for CMS-1500 (08/05) Form |
|---|---|---|
| 10d | Not required | Reserved for local use |
| **11** | **Situational** | **Insured's policy group or FECA number:**<br>*Recipient has two forms of TPL — commercial:* Enter the policy number of the secondary carrier.<br>*Recipient's Secondary Carrier is Medicare:* Enter the policy number of the primary carrier. (Medicare information is entered in Fields 9–9d). |
| 11a | Situational | Insured's date of birth, sex |
| 11b | Situational | Employer's name or school name |
| **11c** | **Situational** | **Insurance plan name or program name:**<br>**Recipient has two forms of TPL — commercial:** Enter the name of the recipient's secondary carrier.<br>**Recipient's Secondary Carrier is Medicare:** Enter the name of the primary carrier (Medicare information is entered in Fields 9–9d). |
| 11d | Situational | Is there another health benefit plan? |
| 12 | Not required | Patient's or authorized person's signature |
| 13 | Not required | Insured's or authorized person's signature |
| **14** | **Situational** | **Date of current: illness, injury, pregnancy**<br>Enter the date (MM DD YY format) if any of the following are applicable:<br>• For services **related to an illness**, enter the date that the first symptoms occurred.<br>• For **injury-related** services, enter the date of the accident.<br>• For **chiropractic** services, enter the date of the first treatment.<br>• For **pregnancy-related** services, enter the date of the first day of the woman's last menstrual period (LMP). |
| 15 | Situational | If patient has had same or similar illness |
| 16 | Situational | Dates patient unable to work in current occupation |
| **17** | **Situational** | **Name of referring provider or other source** |
| 17a | Not required | Not labeled |
| **17b** | **Situational** | **NPI** |
| 18 | Situational | Hospitalization dates related to current services |

# Instructions For Completing The CMS-1500 Form

| Field | Requirement | Field Name and Instructions for CMS-1500 (08/05) Form |
|---|---|---|
| **19** | **Situational** | **Rosorvod for local uso:**<br>*Laboratory services:* Enter the provider's CLIA number.<br>*Anesthesia services:* Enter the total minutes of reportable anesthesia time.<br>*All Other Providers:* Leave this field blank. |
| 20 | Not required | Outside lab? $charges |
| **21** | **Situational** | **Diagnosis or naturo of illnoss or injury:**<br>Enter up to four ICD-9 codes on the lines numbered 1–4.<br>*Please refer to the Billing Guide for your provider type for further instructions.* |
| **22** | **Situational** | **Modicaid rosubmission:** Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank.<br>• In the *Code* area, enter an adjustment or void reason code (see section, *Adjustment/Void reason codes for Field 22*).<br>• In the *Original Reference Number* area, enter the last *paid* Internal Control Number (ICN) of the claim.<br>**Adjustmonts and voids apply to proviously *paid* claims only (including zoro paid claims). Rosubmitting a doniod claim is not considorod an adjustmont.** |
| **23** | **Situational** | **Prior authorization numbor:** If you obtained authorization for an item on this claim, enter your 11-digit Authorization Number in this field.<br>**Entor only ono Authorization Numbor por claim form. Complote additional forms if noodod.** |
| **24A** | **Roquirod** | **Dato(s) of sorvico:**<br>*Dates:* In the **bottom, whito half** of the claim line, enter the begin *(From)* and end *(To)* dates of service. If a service was provided on one day only, enter the same date twice.<br>*Continued on the next page.* |

# Instructions For Completing The CMS-1500 Form

| Field | Requirement | Field Name and Instructions for CMS-1500 (08/05) Form |
|---|---|---|
| **24A** | **Required** | *Continued from the previous page.*<br>To facilitate this, you **must add leading zeros** to one or more sections of the NDC if the container label does not display:<br>• 5 digits in the first section of the NDC<br>• 4 digits in the second section of the NDC<br>• 2 digits in the third section of the NDC<br>**For example**, using the 5-4-2 model described above:<br>• 34-73-1 on the container label is expressed as 00034007301 on the claim<br>• 654-3773-22 on the container label is expressed as 00654377322 on the claim<br>• 1645-222-65 on the container label is expressed as 16457022265 on the claim<br>• 12345-6-7 on the container label is expressed as 12345000607 on the claim<br>• 86541-4885-77 on the container label is expressed as 86541488577 on the claim<br>For **multi-ingredient compounds**, list each component separately, on its own claim line with the 11-digit NDC is this field.<br>For more information and examples on billing physician administered drugs, see the NDC Billing Reference on the HP Enterprise Services website. |
| **24B** | **Required** | **Place of service:** Use the most appropriate Place of Service code in the **bottom, white half** of the claim line. |
| 24C | Not required | EMG |
| **24D** | **Required** | **Procedures, services or supplies CPT/HCPCS modifier:**<br>*CPT/HCPCS Code:* Enter one CPT or one HCPCS code and up to four modifiers on the **bottom, white half** of the claim line.<br>In the **top, shaded half** of the claim line, enter the NDC quantity, i.e., the number of NDC units administered. Fractions of a unit should be expressed in decimal form using up to three decimal places.<br>**Do not include the NDC standard unit of measure** on your claim, i.e., *milliliters, grams* or *each*. |
| **24E** | **Situational** | **Diagnosis pointer:** In the **bottom, white half** of the claim line, enter the line number(s) of the ICD-9 code in Field 21 that relates to the CPT/HCPCS code on this claim line.<br>Please refer to the Billing Guide for your provider type for further instructions. |

# Instructions For Completing The CMS-1500 Form

| Field | Requirement | Field Name and Instructions for CMS-1500 (08/05) Form |
|---|---|---|
| **24F** | **Required** | **$ Charges:** In the **bottom, white half** of the claim line, enter your usual and customary charge for the CPT/HCPCS/NDC on this claim line unless otherwise directed by Medicaid policy (e.g., physician administered drugs are billed at the **Average Wholesale Price (AWP)** and per MSM Chapter 300, radiopharmaceuticals are billed at 100% of **wholesale invoice price**). |
| **24G** | **Required** | **Days or units:** In the **bottom, white half** of the claim line, enter the number of days or the number of units being billed.<br>For NDC quantity, see Field 24D. |
| **24H** | **Situational** | **EPSDT/family plan:** *For providers that bill Family Planning services:* In the **bottom, white half** of the claim line, enter *Y* if services were Family Planning and *N* if they were not.<br>**EPSDT services are identified by EP or TS modifiers used in Field 24D.** |
| **24I** | **Recommended** | **ID qualifier:**<br>*Using **NPI** in Field 24J:* Enter *ZZ* in the **top, shaded half** of the claim line.<br>*Using **API** in Field 24J:* Enter *N5* in the **top, shaded half** of the claim line. |
| **24J** | **Recommended** | **Rendering provider ID#:**<br>*NPI Users:* Enter the provider's taxonomy code in the **top, shaded half** of the claim line. |
| | **Required** | *API Users:* Enter the provider's API in the **top, shaded half** of the claim line.<br>*NPI Users:* Enter the provider's NPI in the **bottom, white half** of the claim line. |
| **25** | **Recommended** | **Federal tax ID number:** Enter the billing provider's Social Security Number (SSN) or Employer Identification Number (EIN). Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. |
| **26** | **Recommended** | **Patient's account number:** Enter up to 17 alpha-numeric characters for your internal patient account number. If entered, this information will be returned to you on your remittance advice. |
| 27 | Not required | Accept assignment? |
| **28** | **Required** | **Total charge:** Add all amounts in column 24F. Enter the total in this field. |
| **29** | **Situational** | **Amount paid:** If the recipient has TPL, enter the amount paid by all other carriers, including Medicare, for the HCPCS/CPT and/or NDC on this claim form. Do not enter the amount received for *all* services on your EOB, and do not include write-off or contractual adjustment amounts. For providers with capitated agreements, enter the contract amount minus co-pay. A zero paid amount is not acceptable for capitated agreements. |

# Instructions For Completing The CMS-1500 Form

| Field | Requirement | Field Name and Instructions for CMS-1500 (08/05) Form |
|---|---|---|
| **30** | **Required** | **Balance due:**<br>*Medicaid is primary coverage:* enter the amount shown in field 28.<br>*Recipient has TPL (including Medicare):* enter the recipient's legal obligation to pay. Do not include write-off, contractual adjustment or behavioral health reduction amounts. |
| **31** | **Required** | **Signature of physician or supplier:** The billing provider or authorized representative must sign and date this field. Original, rubber stamp and electronic signatures are accepted. |
| **32** | **Situational** | **Service facility location information:** Enter the name and **full address** of the location where service was rendered. If the service was rendered in the recipient's home, leave this field blank.<br>**Ambulance providers:** Do not enter *From* and *To* dates in this field. |
| 32a | Not required | NPI# |
| 32b | Not required | Other ID# |
| **33** | **Required** | **Billing Provider Info & Ph#:** Enter the full address of the billing provider. |
| **33a** | **Required** *(for NPI providers only)* | **NPI#:** *For NPI providers only:* Enter the billing provider's NPI. |
| **33b** | **Situational** | **Other ID#:** *API Users:* Enter *N5* followed by the billing provider's API.<br>*NPI Users:* Enter *ZZ* followed by a taxonomy code when available.<br>Do not use spaces, hyphens, dashes, commas, etc. in this field. For example, N51234567899 (for API user) and ZZ1234567899 (for NPI user). |

# Claims Mailing Address

HP Enterprise Services
PO Box 30042
Reno, NV 89520-3042

*Adjustments, voids and any other written correspondence may also be sent to this address.*

# Contact Information

**Customer Service Center**

Claim inquiries and general information

Phone: (877) 638-3472

**Automated Response System (ARS)**

Phone: (800) 942-6511

**Assistance with Prior Authorizations**

Phone: (800) 525-2395

**Requests for Provider Training**

Email: NevadaProviderTraining@hp.com

# Questions?

Thank you for your attention

Please complete the course evaluation before leaving class

Enjoy the remainder of your day