CMS-1500 Claim Form Instructions

May 14, 2013

Change history

Date (mm/dd/yyyy)	Description of changes	Impact
11/1/2007	Provider types 25, 38, 41, 48, 57 and 58 must complete Field 17 for EPSDT referrals. Fields 24A and 24D are affected by new National Drug Code (NDC) requirements. Field 24H is now marked Conditional as it applies to family planning service providers only. Field 32a is now marked Recommended, as the NPI of the service location is not required for claims processing.	Instructions have changed for Fields 17, 24A, 24D, 24H and 32a.
11/19/2008	While most providers bill their usual and customary charge in this field, the Medicaid Services Manual (MSM) specifies that certain services must be billed based on other criteria (e.g., physician administered drugs must be billed at the Average Wholesale Price (AWP) and per MSM Chapter 300, radiopharmaceuticals must be billed at 100 percent of wholesale invoice price). It is important to be familiar with the MSM chapters that apply to the services you provide. The field requirement for Field 32 has changed from Required to Conditional. Some services are provided in the recipient's home and therefore do not require a servicing facility address. The field requirement for Field 32a has been changed from Required to Not Required as this information is not required in order to process the claim	Instructions have changed for Field 24F.
12/29/2008	Field 33b is now labeled as Conditional instead of required. API users must complete this field, but it is required for NPI users only when they use a taxonomy code.	Field 33b
4/1/2010	These fields are no longer required. EPSDT services are identified by EP or TS modifiers used in Field 24D. Rendering provider information is recorded in Field 24J	Instructions have changed for Fields 17 and 17a.
05/14/2013	Updated all sections	All

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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.

Questions?

If you have any questions, please call the Customer Service Center at (877) 638-3472.

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.

Provider training

HP Enterprise Services and the Division of Health Care Financing and Policy (DHCFP) offer free training classes throughout the year.

The Provider Training Catalog describes the training program and lists current training schedules. Billing staff, billing agencies, direct practitioners/health care providers, office managers, admitting and front-desk staff, etc. are invited to attend.

If you have questions or comments regarding training, contact the HP Enterprise Services Provider Training Unit at:

Phone: (877) 638-3472 (select option 2, then option 0, then option 4)
Email: NevadaProviderTraining@hp.com

Web announcements

Web announcements appear on the homepage at http://www.medicaid.nv.gov and on the Announcements/Newsletters webpage.

Be sure to check this website at least weekly for these important updates.

Adjustment/Void reason codes for Field 22

To adjust or void a *previously paid* claim, use an adjustment or void reason code to complete the *CODE* area of Field 22 (MEDICAID RESUBMISSION). Resubmitting a *denied* claim is not considered an adjustment or void.

Adjustment reason codes

Use one of the following codes in Field 22 when adjusting a previously paid claim.

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)

Void Reason Codes

Use one of the following codes in Field 22 when voiding a previously paid claim.

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

CMS-1500 field requirements

Required

Fields marked *Required* in the 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 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

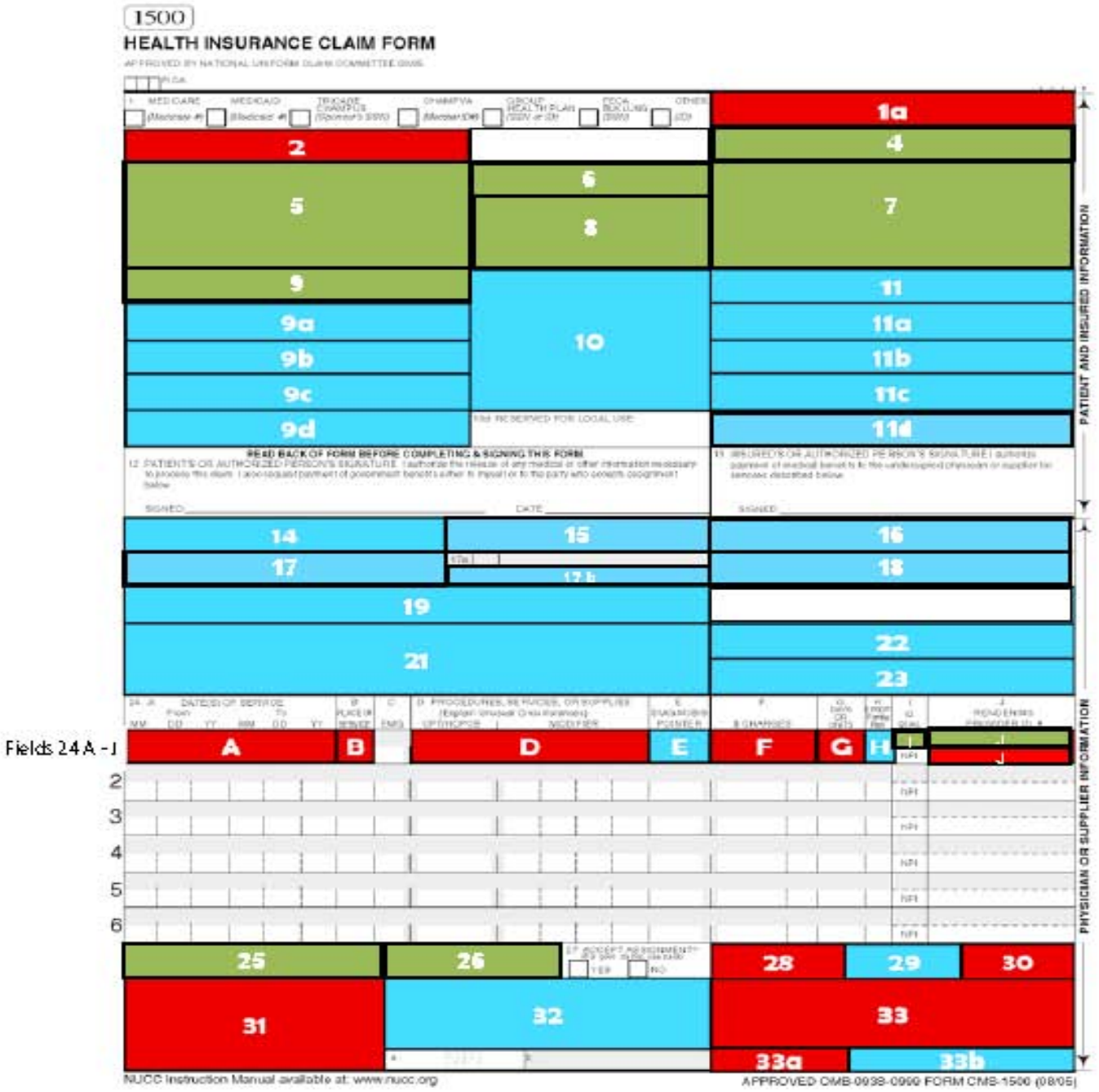
Fields marked *Not Required* are not used in processing the claim, although the provider is free to populate the field if desired. For example, providers may use Field 3 to enter the recipient's birth date and sex, but the data will not be used to adjudicate the claim.

Third Party Liability claims

Third Party Liability (TPL) claims, including Medicare crossover claims, may contain only one completed claim line per claim form.

Shaded CMS-1500 (08/05) field requirements

The CMS-1500 (08/05) claim form is shown below with Nevada Medicaid *Required* fields shaded red, *Situational* fields shaded blue, and *Recommended* fields shaded green. (On a non-color printout, *Required* fields will appear darkest.)



Instructions for completing the CMS-1500 (08/05) claim 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:** *Recipient has TPL with **Medicare** coverage:* Enter the recipient's Medicare number. *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:** *Recipient has **Medicare** coverage:* Enter the word *Medicare* followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus). *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.

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:** *Recipient has two forms of TPL — commercial:* Enter the policy number of the secondary carrier. *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:** **Recipient has two forms of TPL — commercial:** Enter the name of the recipient's secondary carrier. **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** Enter the date (MM DD YY format) if any of the following are applicable: • For services **related to an illness**, enter the date that the first symptoms occurred. • For **injury-related** services, enter the date of the accident. • For **chiropractic** services, enter the date of the first treatment. • 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

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
19	**Situational**	**Reserved for local use:** *Laboratory services:* Enter the provider's CLIA number. *Anesthesia services:* Enter the total minutes of reportable anesthesia time. *All Other Providers:* Leave this field blank.
20	Not required	Outside lab? $charges
21	**Situational**	**Diagnosis or nature of illness or injury:** Enter up to four ICD-9 codes on the lines numbered 1–4. *Please refer to the Billing Guide for your provider type for further instructions.*
22	**Situational**	**Medicaid resubmission:** Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. • In the *Code* area, enter an adjustment or void reason code (see section, *Adjustment/Void reason codes for Field 22*). • 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.**
23	**Situational**	**Prior authorization number:** If you obtained authorization for an item on this claim, enter your 11-digit Authorization Number in this field. **Enter only one Authorization Number per claim form. Complete additional forms if needed.**
24A	**Required**	**Date(s) of service:** *Dates:* In the **bottom, white 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. In the **top, shaded half** of the claim line, enter qualifier N4 followed by the drug's **11-digit NDC.** The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. *Continued on the next page.*

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
24A	**Required**	*Continued from the previous page.* To facilitate this, you **must add leading zeros** to one or more sections of the NDC if the container label does not display: • 5 digits in the first section of the NDC • 4 digits in the second section of the NDC • 2 digits in the third section of the NDC **For example**, using the 5-4-2 model described above: • 34-73-1 on the container label is expressed as 00034007301 on the claim • 654-3773-22 on the container label is expressed as 00654377322 on the claim • 1645-222-65 on the container label is expressed as 16457022265 on the claim • 12345-6-7 on the container label is expressed as 12345000607 on the claim • 86541-4885-77 on the container label is expressed as 86541488577 on the claim For **multi-ingredient compounds**, list each component separately, on its own claim line with the 11-digit NDC is this field. 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:** *CPT/HCPCS Code:* Enter *one* CPT or *one* HCPCS code and up to four modifiers on the **bottom, white half** of the claim line. 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. **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. Please refer to the Billing Guide for your provider type for further instructions.

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. 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. **EPSDT services are identified by EP or TS modifiers used in Field 24D.**
24I	**Recommended**	**ID qualifier:** *Using **NPI** in Field 24J:* Enter *ZZ* in the **top, shaded half** of the claim line. *Using **API** in Field 24J:* Enter *N5* in the **top, shaded half** of the claim line.
24J	**Recommended**	**Rendering provider ID#:** *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. *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.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
30	**Required**	**Balance due:** *Medicaid is primary coverage:* enter the amount shown in field 28. *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. **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. *NPI Users:* Enter *ZZ* followed by a taxonomy code when available. Do not use spaces, hyphens, dashes, commas, etc. in this field. For example, N51234567899 (for API user) and ZZ1234567899 (for NPI user).