



HEALTH INSURANCE CLAIM FORM

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

CARRIER

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																			
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
CITY					STATE					8. RESERVED FOR NUCC USE					CITY					STATE									
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 OR GROUP NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. RESERVED FOR NUCC USE														
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (Street, Other (Designate))					c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>														
c. RESERVED FOR NUCC USE					10d. CLAIM CODES (NUCC)					d. INSURANCE PLAN NAME OR PROGRAM NAME					11. INSURANCE PLAN NAME OR PROGRAM NAME														
d. INSURANCE PLAN NAME OR PROGRAM NAME					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of information for processing of this claim. I also request payment of government benefits either to the patient or to the provider as indicated below.					10d. CLAIM CODES (NUCC) YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of information for processing of this claim. I also request payment of government benefits either to the patient or to the provider as indicated below.														
SIGNED _____					SIGNED _____					14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY														
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY					17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES														
19. ADDITIONAL CLAIM INFORMATION (by NUCC)					21. DIAGNOSIS OR NATURE OF INJURY Relate A-L to service line below (24E) ICD Incl.					22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER														
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPIC Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #											
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Reserved 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.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()																			
SIGNED _____ DATE _____					a. NPI					b. NPI					a. NPI					b. NPI									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 (02/12)

Please note the following:

- Using the 02/12 version with the 08/05 format does not work. The diagnosis codes for Box 21 end up in the wrong location, and the Claims Unit will not key them to fit.
- If claims do not follow the 02/12 format, payment of your claims could be affected. Work with your software vendor to fix this issue.

In conjunction with the incorrect claim format, boxes for diagnosis code pointers are being completed incorrectly:

- 24E is alphabetic, not numeric.
- We currently accept diagnosis codes in Boxes A–D on the CMS-1500 (02/12); for the 837P X12 5010 electronic claim this equate to 1–4. Anything submitted in boxes other than A–D on the CMS-1500 (02/12) or other than 1–4 on the 837P X12 5010 electronic claim could cause denial of line or claim.
- **Box 10d Claim Codes**
 - No longer scanned for the member ID. Montana Medicaid scans 1a, 9a, and 11 for the member ID.
- **Box 17 Name of Referring Provider or Other Source**
 - Montana Medicaid accepts with referring provider's name.
- **Box 17a Unlabeled Field**
 - Montana Medicaid reserves for Passport to Health referral number.
- **Box 17b NPI and Unlabeled Field**
 - Montana Medicaid reserves for Indian Health Services referral number.
- **Box 21 Diagnosis or Nature of Illness or Injury**
 - Decimal points are not allowed in Boxes A–L for diagnosis pointer.
- **Box 29 Amount Paid**
 - Montana Medicaid reserves for third party liability payments.

Providers rebilling a claim after April 1 must use the 02/12 version even if the 08/05 version was used to bill the claim.

Although a sample CMS-1500 (02/12) is on the Forms page of the Montana Medicaid Provider Information website, <http://medicaidprovider.hhs.mt.gov>, claim forms must be ordered from an authorized vendor.

For more information, see the instruction manual on the NUCC website:

http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02.pdf