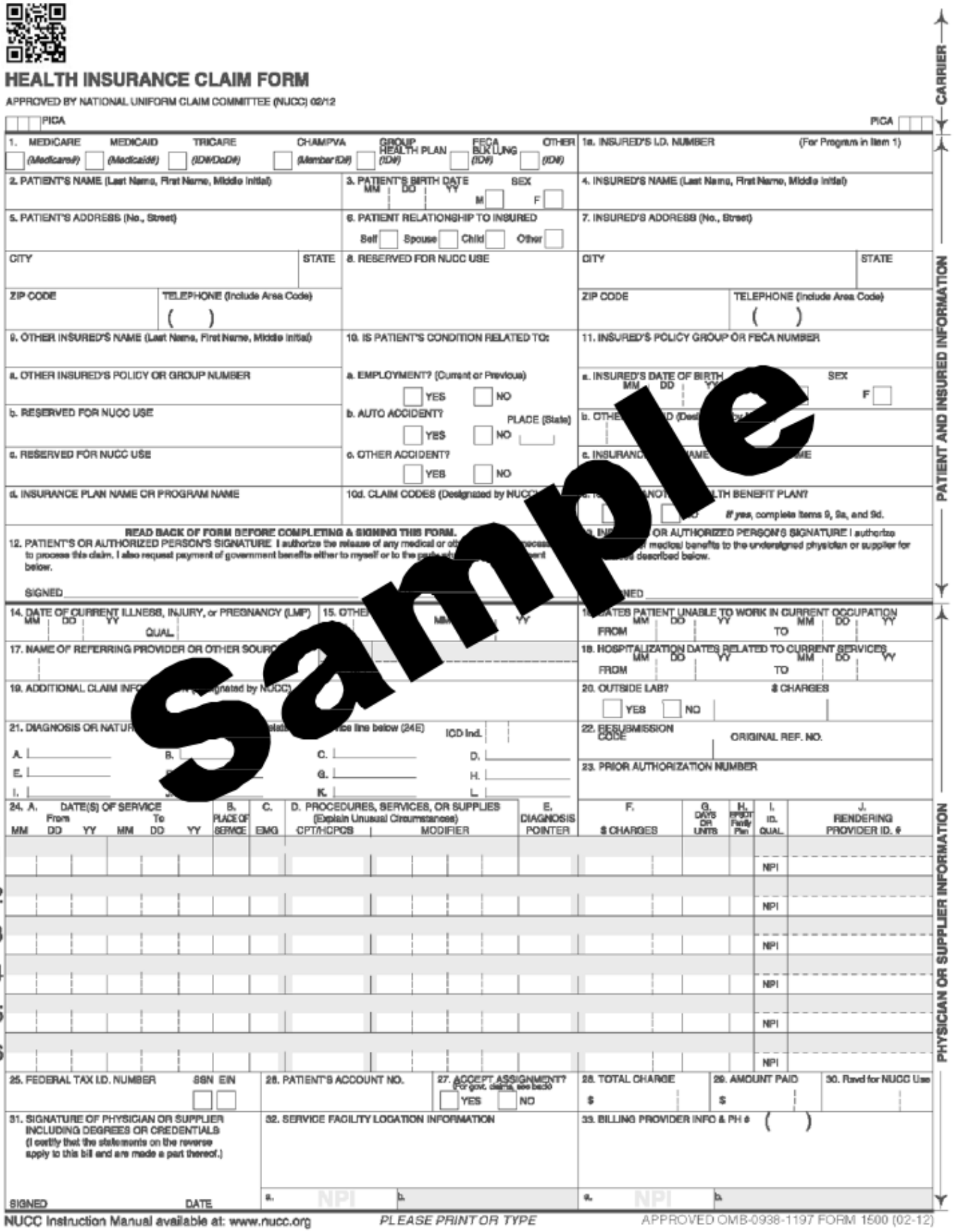
CMS-1500 Claim Form Sample



HEALTH INSURANCE CLAIM FORM

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

PICA

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

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE 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

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

19. ADDITIONAL CLAIM INFO (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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.

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										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Information

The table below Identifies the CMS-1500 claim form fields and provides instructions. Although a sample CMS-1500 is on the Claims Information page of the Montana Healthcare Programs Provider Information website, MedicaidProvider.mt.gov, claim forms must be ordered from an authorized vendor.

For additional information, see the CMS-1500 Reference Instructional Manual on the NUCC website, https://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2024_07-v12.pdf.

Field Number	Description	Instructions
1	Insurance Type	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked. Check Medicaid.
1a	Insured ID Number	Enter the insured's ID number as shown on member's Medicaid ID card. This is a required field.
2	Patient's Name	Enter the patient's full last name, first name, and middle initial as indicated on the Medicaid ID card.
3	Patient's DOB and Sex	Enter the patient's 8-digit birthday in MM/DD/YYYY format. Put an X in the applicable M/F box to indicate the recipient's gender. Only one box can be marked. If gender is unknown, leave blank.
4	Insured Name	Enter insured's full last name, first name, and middle initial as indicated on the member's Medicaid ID card.
5	Patient's Address	Includes multiple fields. Enter the patient's address including street, city, state, and ZIP code. Patient's telephone number includes the area code.
6	Patient Relationship to Insured	Enter an X in the Self box.
7	Insured Address	Includes multiple fields. Enter the insured's address. The telephone number does not have to be reported in this box.
8	Reserved for NUCC Use	Leave blank.
9	Other Insured's name	Enter the insured's name if 11d was marked Yes. If field 9, 9a, or 9d are filled out, a primary insurance EOB will be required to be submitted with the claim.
9a	Other Insured's Policy or Group Number	Enter the insured's primary insurance policy number if 11d was marked Yes.

Field Number	Description	Instructions
9b	Reserved for NUCC Use	Leave blank.
9c	Reserved for NUCC Use	Leave blank.
9d	Insurance Plan Name or Program Name	Enter the primary insurance plan name if 11d was marked Yes.
10a-c	Is Patient's Condition Related To	Enter an X in the correct box to indicate whether one or more of the services described in Box 24 are for the result of an accident that occurred on the job, result of an automobile, or other accident. The state postal code where the accident occurred must be reported if Yes is marked in 10b for Auto Accident. Any item marked Yes indicates there may be other applicable insurance coverage that would be primary, such as automobile insurance. Primary insurance information must then be shown in Box 11.
10d	Reserved for NUCC Use	Leave blank.
11	Insured's Policy Group or FECA Number	Enter the member's Medicaid ID number. If Box 4 is completed, then this field should be completed.
11a	Insured's DOB, Sex	Enter the 8-digit date of birth MM/DD/YYYY of the insured. Enter an X to indicate the gender of the insured. Only one box can be marked. If gender is unknown, leave blank.
11b	Other Claim ID (Designated by NUCC)	Applicable claim identifiers are designated by NUCC: Property Casualty Claim Number. Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.
11c	Insurance Plan Name or Program Name	Enter the name of the insurance plan or program of the insured as indicated in Box 1a.
11d	Is There Another Health Benefit Plan?	Enter an X in the Yes box if the member has an insurance other than the plan indicated in Box 1. If Yes is checked, complete 9, 9a, and 9d. If no other insurance, check No.
12	Patient's or Authorized Person's Signature and Date of Signature	Enter Signature on File or legal signature and the date signed. If there is no signature on file, leave blank or enter No Signature on File.
13	Insured's or Authorized Person's Signature	Enter Signature on File or legal signature. If there is no signature on file, leave blank or enter No Signature on File.

Field Number	Description	Instructions
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the date of the member's illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier (431 Onset of Current Symptoms or Illness or 484 Last Menstrual Period) to identify which date is being reported.
15	Other Date	Enter the date related to the patient's condition or treatment as applicable. Enter the applicable qualifier (454 Initial Treatment; 304 Latest Visit or Consultation; 453 Acute Manifestation of a Chronic Condition; 439 Accident; 455 Last X-ray; 471 Prescription; 090 Report Start (Assumed Care Date); 091 Report End (Relinquished Care Date); 444 First Visit or Consultation) to identify which date is being reported.
16	Dates Patient Unable to Work in Current Occupation.	Enter the time span the patient is or was unable to work if the patient is employed and is unable to work in current occupation.
17	Name of Referring Provider	Enter the name of the referring provider if applicable.
17a	Passport Number	Enter the Montana Medicaid 7-digit Passport referral number if applicable.
17b	Referring Provider NPI	Enter the Indian Health Service, Tribal 638, or Urban Indian Health provider NPI if applicable.
18	Hospitalization Dates Related to Current Services	Enter the inpatient hospital admission date followed by the discharge date, or if not discharged, leave field blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information	Enter any additional claim information here (e.g., School Team number. Format needs to be "Team XX".).

Field Number	Description	Instructions
20	Outside Lab	Enter an X in the appropriate Yes/No box as applicable. Selecting Yes indicates that the reported service was provided by an entity other than the billing provider. Selecting No or leaving blank indicates that no purchased services are included on the claim. If Yes is checked, enter the purchase price under Charges and complete Box 32. Each purchased service must be reported on a separate claim form because only one charge can be entered. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.
21	Diagnosis Codes	Enter the applicable ICD indicator to identify which version of ICD codes (9 for ICD-9 or 0 for ICD-10) is being reported between the vertical, dotted lines in the upper right-hand portion of the box. Enter the ICD codes to identify the patient's diagnosis and/or condition. List no more than 12 diagnosis codes. Relate lines A–L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22	Resubmission code and/or Original Reference Number.	Montana Medicaid does not use box 22 for paper claims. To adjust a claim by paper Montana Medicaid requires the Individual Adjustment Request form. You may need to attach a copy of the claim depending on the corrections you are making to your previously paid claim.
23	Prior Authorization	Enter prior authorization number as assigned by Montana Medicaid if applicable.
24A	Dates of Service	Enter the from and to dates of service for each line of service you are billing.
24B	Place of Service (POS)	Enter the POS for each line of service you are billing.
24C	Emergency	Enter Y for emergency related or N for not emergency related for each line of service you are billing.
24D	Procedures, Services, or Supplies	Enter the CPT codes in the left most box and any applicable modifiers between the dashed lines on the right for each line of service you are billing.

Field Number	Description	Instructions
24E	Diagnosis Pointer	Enter the letter from the line in box 21 to indicate the diagnosis that applies to the line for each line of service you are billing. Up to 4 pointers are accepted.
24F	Charges	Enter the total amount being charged for each line of service you are billing.
24G	Days or Units	Enter the total number of days or units you are billing for each line. This field is numeric only.
24H	EPSDT Indicator	Enter the EPSDT, family planning, or nursing home indicator for each line of service you are billing if applicable.
24I	Rendering Provider Taxonomy Qualifier	Enter ZZ for taxonomy qualifier in the shaded section if applicable for each line of service you are billing.
24J	Rendering Provider NPI and taxonomy	Enter the rendering provider's NPI in the unshaded section and taxonomy in the shaded section if applicable for each line of service you are billing. Only one rendering provider is allowed per claim form.
25	Federal Tax ID Number	Enter your federal Tax ID/EIN.
26	Patient's Account Number	Enter your organization assigned patient account number if applicable.
27	Accept Assignment	Indicates that the provider agrees to accept assignment under the terms of the Medicaid program. Enter an X in the correct box. Only one box can be marked.
28	Total Charge	Enter the total charge being billed on the claim for all lines.
29	Amount Paid	Enter the amount paid by any primary insurance. This field is not for Medicare payment information.
30	Reserved for NUCC Use	Leave blank.
31	Signature of Physician	Enter the legal signature of the provider, supplier representative, or Signature on File.
32	Service Facility Location Information	Enter the name and complete address of the location where services were rendered.
32a	NPI #	Enter the NPI of the service facility as applicable.
32b	Other ID.	Enter the taxonomy of the service facility as applicable.
33	Billing Provider Info and Telephone Number	Enter the name and complete physical address including ZIP +4- and 10-digit telephone number of the billing provider. Montana Medicaid does not accept post office boxes in this field.
33a	NPI #.	Enter the billing provider's NPI if applicable.
33b	Other ID	Enter either the ZZ qualifier and provider taxonomy or G2 qualifier followed by the provider's 7-digit atypical provider ID (API) (e.g., G2XXXXXX).