Tips for Completing the CMS-1500 Form

This tip book is designed to help you complete the CMS-1500 (02/12).

iCircle Care will accept both 1500 claim forms — version 08/05 and version 02/12 until March 31, 2014. **If the version 08/05 form is submitted on or after April 1, 2014, it will be returned, advising to submit on the CMS-1500 (02/12) claim form.**

The NUCC has released an updated *1500 Health Insurance Claim Form Reference Instruction Manual*, which is available under the "1500 Claim Form" tab via their website at www.nucc.org.

Please reference the manual, along with this tip book, to help ensure that claims are submitted accurately.

Ordering Forms & Submitting

Ordering Claim Forms: You may order CMS-1500 forms at: http://bookstore.gpo.gov, or by calling 202-512-1800.

Submitting Claims: All paper claims should be submitted to:
iCircle MLTC
P.O. Box 1320
Webster, NY 14580

Form Completion: Details on how to complete the form are outlined on the following pages. If you have questions, please contact your Provider Relations Representative.

Key (use for information presented on the following pages)

R	Required in filing a claim
NR	Not required, not used
S	Situational, only use if appropriate specific to claim

Key: "R" - Required in filing a claim
"NR" - Not required, not used
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HEALTH INSURANCE CLAIM FORM

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

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PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medica) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#) — R

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — R

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — R

3. PATIENT'S BIRTH DATE MM DD — R SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — R

5. PATIENT'S ADDRESS (No., Street) — R

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse — R Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street) — S

CITY | STATE

8. RESERVED FOR NUCC USE — NR

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) — S

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER — NR

a. OTHER INSURED'S POLICY OR GROUP NUMBER — S

a. EMPLOYMENT? (Current or Previous) YES — S NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY — NR SEX M ☐ F ☐

b. RESERVED FOR NUCC USE — NR

b. AUTO ACCIDENT? YES — S NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC) — NR

c. RESERVED FOR NUCC USE — NR

c. OTHER ACCIDENT? YES — S NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME — NR

d. INSURANCE PLAN NAME OR PROGRAM NAME — S

10d. CLAIM CODES (Designated by NUCC) — S

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — R YES ☐ NO *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. — R

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. — R

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

15. OTHER DATE QUAL. — S MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — S TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — R
Note: Field required for ancillary claims.

17a. — NR

17b. NPI — R

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) — NR

20. OUTSIDE LAB? YES ☐ NO ☐ — R $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — R ICD Ind. — R

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — NR ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER — S

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		R	R	S	R	S	R	R	R	S	R NPI R
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER — R SSN EIN

26. PATIENT'S ACCOUNT NO. — S

27. ACCEPT ASSIGNMENT? (For go[illegible]ns, see back) YES — R NO ☐

28. TOTAL CHARGE $ — R

29. AMOUNT PAID $ — S

30. Rsvd for NUCC Use — NR

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.) — R

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — R

a. — S NPI

b. — S

33. BILLING PROVIDER INFO & PH # ( ) — R

a. — R NPI

b. — R

SAMPLE

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Key: "R" - Required in filing a claim
"NR" - Not required, not used
"S" - Situational, only used if appropriate specific to claim

1. TYPE OF HEALTH INSURANCE COVERAGE R
Select "Other"

1A. INSURED ID NUMBER R
Enter the subscriber's identification number **and three-character prefix required.**

2. PATIENT'S NAME R Last name, First name, Middle initial
Enter the patient's last name, first name and middle initial

3. PATIENT'S BIRTH DATE/SEX R
Enter the patient's date of birth using the eight-digit date format (MM/DD/CCYY)
Next, select the patient's gender

4. INSURED'S NAME R Last name, First name, Middle initial
Enter the insured's last name, first name and middle initial

5. PATIENT'S ADDRESS/TELEPHONE NUMBER R
Enter the patient's permanent mailing address and telephone number

6. PATIENT'S RELATIONSHIP TO THE INSURED R Note - If the patient is not the subscriber, do not select "Self"
Select the appropriate box for patient's relationship to the insured person

7. INSURED'S ADDRESS/TELEPHONE NUMBER S
Enter the insured person's permanent mailing address (complete if different from the patient's address)

8. RESERVED FOR NUCC USE NR

9. OTHER INSURED'S NAME S
Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.

9A. OTHER INSURED'S POLICY OR GROUP NUMBER S
Enter the other insured person's policy or group number **- field is very important for COB claims**

9B. RESERVED FOR NUCC USE NR

9C. RESERVED FOR NUCC USE NR

9D. INSURANCE PLAN NAME OR PROGRAM NAME S
Enter the name of the other insured person's insurance plan or program name

10A-D. IS PATIENT'S CONDITION RELATED TO:
For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank

10A. Select whether the patient's condition is related to employment S

10B. Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation S

10C. Select whether the patient's condition is related to any other type of accident S

10D. CLAIM CODES (DESIGNATED BY NUCC) S

(11 thru 11d, refer to subscriber coverage)

11. INSURED'S POLICY GROUP OR FECA NUMBER NR
Enter the subscriber's group number

11A. INSURED'S DATE OF BIRTH, SEX NR
Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender

11B. OTHER CLAIM ID (DESIGNATED BY NUCC) NR

11C. INSURANCE PLAN NAME OR PROGRAM NAME NR
Enter the subscriber's insurance plan name, include name of state

11D. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN R
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE R
Enter the phrase SIGNATURE ON FILE, or include legal signature (and date) of patient or authorized person.

13. INSURED OR AUTHORIZED PERSON'S SIGNATURE R **Enter the phrase SIGNATURE ON FILE, or include legal signature (and date) of patient or authorized person. If neither, leave blank or state no signature on file.**

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) S
Enter the date using an eight-digit date format (MM/DD/CCYY)

15. OTHER DATE S
Enter the date using an eight-digit date format (MM/DD/CCYY) **Need qualifier, see NUCC manual**

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S
Enter the date using an eight-digit date format (MM/DD/CCYY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE R **NOTE - Field required for Ancillary claims**
Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required only if there is a referring, ordering or supervising provider.

17A. OTHER ID# NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier)

17B. NPI # R
Enter the 10-digit NPI number of the referring, ordering or supervising provider

18. HOSPITAL DATES RELATED TO CURRENT SERVICES S
Enter the hospital dates using an eight-digit date format (MM/DD/CCYY)

19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC) NR
Not required

20. OUTSIDE LAB/CHARGES R
Select "Yes" or "No" to indicate if the claim includes charges for lab services performed outside of the physician's office. If Yes," enter the total charges.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R
Enter the ICD- CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. **Up to 11 additional ICD-CM codes can be entered. ICD Ind. required.**

22. RESUBMISSION NR
Not required

23. PRIOR AUTHORIZATION NUMBER S
Add complete authorization number

24. SHADED AREA – SUPPLEMENTAL INFORMATION –
The shaded area of field 24a - 24h was created to accommodate supplemental information **(i.e., NDC)**
For more information, see the National Uniform Claim Committee's Website at www.nucc.org.

24A. DATE(S) OF SERVICE R
Enter the dates of service using an eight-digit date format (MM/DD/CCYY) **Note - Cannot be a future date.**

24B. PLACE OF SERVICE R
Enter the appropriate two-digit Place of Service code

24C. EMG S
If this service was an emergency, enter "Y" for "Yes," or leave blank if "No"

24D. PROCEDURES, SERVICES, OR SUPPLIES R
Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable

24E. DIAGNOSIS POINTER R
Enter the appropriate ICD- CM diagnosis code or codes for each procedure performed. Enter one code per line of service. **Note - Use alpha (A-L), not numeric.**

24F. CHARGES R
Enter the charge for each line of service. **Note - Do not include discounts/negative amounts.**

24G. DAYS OR UNITS R
Enter the number of days or units for each line of service

24H. EPSDT/FAMILY PLAN S
If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code

24I. ID QUALIFIER - SHADED FIELD R
reserved for taxonomy code qualifier, "ZZ "

24J. RENDERING PROVIDER ID. # R **Note - Required for Group Practices.**
SHADED FIELD
reserved for taxonomy code

NON-SHADED FIELD R
Enter the performing provider's 10-digit NPI number in the non-shaded area

25. FEDERAL TAX I.D. NUMBER R
Enter the Federal Tax I.D. Number for the provider of service. Select the appropriate field for SSN or EIN.

26. PATIENT ACCOUNT NUMBER S
Enter account number assigned to the patient, if applicable

27. ACCEPT ASSIGNMENT R
Select "Yes" **Note - Only if the provider participates with iCircle Care.**

28. TOTAL CHARGE R **Note - If multiple pages, put total on last page only.**
Enter the total charge for all services (total of all charges in 24f)

29. AMOUNT PAID S
Enter the amount paid by the patient or other payers on covered services only.

30. RSVD FOR NUCC USE NR

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS R
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY). **Should match rendering provider signature - field 24J**

32. SERVICE FACILITY LOCATION INFORMATION R **Note - Required when different from Billing Provider.**
Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.

Note: Per the NUCC Instruction Manual, Field 32 is required if Field 20 is checked "yes."
For more information, see the National Uniform Claim Committee's Website at www.nucc.org.

32A. NPI S
Enter the 10-digit NPI number of the service facility location

32B. OTHER ID# S
reserved for taxonomy code **- including ZZ qualifier**

33. BILLING PROVIDER INFO AND PH# R **Note - Provide physical address in this field.**
Enter the information of the billing provider or supplier to be paid for services

33A. NPI R
Enter the 10-digit NPI number of the billing provider

33B. OTHER ID # R **Note - Required for Individual/Solo Practices.**
reserved for taxonomy code**- including ZZ qualifier**

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Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

For additional information on Place of Service Codes visit:
http://www.cms.gov/Medicare/Coding/place-of-service-codes/

Instructions and Examples of Supplemental Information in Item Number 24

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

For additional information for reporting NDC units, see the National Uniform Claim Committee's website at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11. **Note - When applicable, not all ID cards contain a group number.**
- Put the physician or supplier's billing name, address, zip code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

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