

## **Chapter 3: Health Insurance Claim Form**

### **Purpose of Claim Form**

The CMS-1500 form is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the claims prepared and submitted from physicians and suppliers, with the exception of ambulance suppliers, whether or not the claims are assigned. It has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

The following sections contain instructions concerning the confidentiality and disclosure of information acquired and maintained by CMS, contractors (i.e., Medicare intermediaries and carriers), providers, and state agencies in the administration of the health insurance program. These instructions comply with the statutes and regulations governing disclosure of information, specifically, Section 1106 of the Social Security Act, the Freedom of Information Act (FOIA) and implementing Health and Human Services (HHS) FOIA regulations at 45 CFR Part 5, and CMS Confidentiality and Disclosure regulations at 42 CFR 401.101, et seq.

### **Privacy Act of 1974**

The purpose of the Privacy Act of 1974 is to provide safeguards for individuals against an invasion of privacy by federal agencies. Among other things, federal agencies are required to permit an individual to: (1) determine what records pertaining to the individual are collected, used, or disseminated by such agencies; (2) prevent records pertaining to the individual obtained by federal agencies for a specific purpose from being used for another purpose without the individual's consent; and (3) gain access to information pertaining to the individual in federal agency records and to correct such records when appropriate.

### **Freedom of Information Act**

The FOIA (found in Title 5 of the United States Code, Section 552) was enacted in 1966 and provides that, upon request from any person, a federal agency must release any agency record unless that record falls within one of the nine statutory exemptions and three exclusions. The FOIA was amended by Public Law 104-231. The new amendments stress agency responsibilities for making available electronic records and electronic communications, providing records in electronic form, and creating indices of records to assist the public in finding records.

## Security Standards

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services (HHS) to establish national standards for the security of electronic health care information. The final rule adopting HIPAA standards for security was published in the Federal Register (FR) (45 CFR Parts 160, 162, and 164) on February 20, 2003. This final rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information by the health plans, health care clearinghouses, and certain health care providers. The standards are delineated into either required or addressable implementation specifications and are required under Subtitle F, Sections 261-264 of HIPAA (Pub.L. 104-191). In addition, a new Part C (Administrative Simplification) was added to Title XI of the Social Security Act, which consists of Sections 1171-1179. These statutory sections are discussed in the Transactions Rule, at 65 FR 50312, on pages 50312-50313, and in the final rules adopting Standards for Privacy of Individually Identifiable Health Information, published on December 28, 2000, at 65 FR 82462 (Privacy Rules), on pages 82470-82471, and on August 14, 2002, at 67 FR 53182.

## Identifiable Beneficiaries

In general, no information may be released except to the beneficiary (or his/her legal guardian) without the beneficiary's (or legal guardian's) explicit **written** authorization. In cases requiring the beneficiary's consent to disclosure, the authorization may be in any form, but it **must**: (1) be signed and dated; (2) specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed; (3) specify the record(s), information, or type(s) of information which may be disclosed; and (4) indicate whether the consent is a one-time or on-going release of records. A contractor will not honor a blanket consent to disclose all beneficiary records to unspecified individuals or organizational units.

### **Release of Eligibility Data When the Individual is Unable to Sign an Authorization**

In situations where the individual has not signed a statement authorizing the provider to pursue a Medicare claim, the disclosure of information to the provider should be treated as a routine use disclosure. A "routine use" is a disclosure of information which may be made without the individual's written consent, because the disclosure is compatible with the purpose for which the information was collected in the first place.

## Confidentiality of Supplier and Supplier Records

Medicare information may not be accepted from providers, physicians, and other suppliers of services on a confidential basis, expressed or implied, since any medical information obtained by a contractor is subject to disclosure to the individual to whom it pertains. No medical information marked “confidential” will be accepted on that basis and any medical information received by the contractor may be disclosed to the patient or his/her representative upon request, either directly or through designated professional medical personnel. If a provider, physician, or other supplier of services documents medical findings on medical forms preprinted “confidential,” or the provider or other supplier of services routinely stamps all records “confidential,” such records, when transmitted to the contractor, are to be accompanied by a signed statement to the effect that the provider, physician, or supplier understands that the information is subject to disclosure at the request of the patient or his/her representative under the Privacy Act.

For more information, refer to Chapter 6 (Disclosure of Information) of Pub. 100-01, *Medicare General Information, Eligibility, and Entitlement*  
<http://www.cms.hhs.gov/manuals/downloads/ge101c06.pdf>

## Time Limits for Filing

Medicare regulations, at 42 CFR 424.44, define the timely filing period for Medicare fee-for-service claims. In general, such claims **must** be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is the second year after the year in which such services were furnished. (**Note:** Beginning with the claims filing period ending December 31, 2004, and thereafter, Medicare contractors shall no longer accept Statements of Intent (SOIs) to extend the timely filing period of claims, since the SOI provision at 42 CFR 424.45 has been removed effective May 24, 2004.)

The table that follows illustrates the timely filing limit for dates of service in each calendar month. (**Note:** The number specified in “Months to File” represents the number of full months remaining **after** the month in which the service was rendered.)

Date of Service In	Timely Filing Date	Months to File	Date of Service In	Timely Filing Date	Months to File
January	December 31: Service year plus 1 year	23	July	December 31: Service year plus 1 year	17
February	December 31: Service year plus 1 year	22	August	December 31: Service year plus 1 year	16
March	December 31: Service year plus 1 year	21	September	December 31: Service year plus 1 year	15
April	December 31: Service year plus 1 year	20	October	December 31: Service year plus 1 year	28
May	December 31: Service year plus 1 year	19	November	December 31: Service year plus 1 year	27
June	December 31: Service year plus 1 year	18	December	December 31: Service year plus 1 year	26

### Mandatory Submission of Claims

Section 1848(g)(4) of the Social Security Act requires that physicians and suppliers complete and submit claims to Medicare carriers for services furnished (on or after September 1, 1990) within twelve (12) months of the service date. (**Note:** Physicians and Suppliers **must** submit claims to Medicare whether they are participating or not.) Only assigned claims submitted more than twelve months after the service date will be subject to a ten percent (10%) reduction of the amount that would otherwise have been paid. Payment on an assigned claim submitted by a physician or other supplier twelve months or longer after the service is furnished, shall be reduced by ten percent from the amount that would have otherwise been paid (see Chapter 1 of Pub. 100-04, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> for details).

For more information on supplier responsibility for filing claims to Medicare, refer to §1848(g)(4) of Title XVIII of the Social Security Act, [http://www.ssa.gov/OP\\_Home/ssact/title18/1848.htm#g4](http://www.ssa.gov/OP_Home/ssact/title18/1848.htm#g4)

## Completing the Claim Form

The CMS-1500 form has space allocated for physicians and suppliers to provide information on other health insurance. This information should be used in determining whether the Medicare patient has other coverage which should be billed prior to Medicare payment, or whether there is a Medigap or supplemental policy for which payments are to be made to a participating physician or supplier. For more information on completing the CMS-1500 form, refer to Chapter 26 of Pub. 100-04, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

If a claim is submitted with incomplete or invalid information, it may be returned to the submitter as unprocessable. Use the following instructions for completing the CMS-1500 form.

In order to skip to a specific item description, click on the item in the image of the CMS-1500 form below.

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																							
1. MEDICARE <input type="checkbox"/> (Medicare #) / MEDICAID <input type="checkbox"/> (Medicaid #) / TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) / CHAMPVA <input type="checkbox"/> (Member ID) / GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) / FECA BLK LUNG <input type="checkbox"/> (SSN) / 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. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																													
ZIP CODE					TELEPHONE (Include Area Code) ( )					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					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) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																													
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.																													
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																																																	
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 _____										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. SIGNED _____																													
14. DATE OF CURRENT: MM DD YY										ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
19. RESERVED FOR LOCAL USE																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																													
1. _____										3. _____										23. PRIOR AUTHORIZATION NUMBER																													
2. _____										4. _____																																							
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. EPS01 Family Plan					I. ID. CUAL					J. RENDERING PROVIDER ID. #				
1																				NPI _____																													
2																				NPI _____																													
3																				NPI _____																													
4																				NPI _____																													
5																				NPI _____																													
6																				NPI _____																													
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$									
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](http://www.nucc.org)

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓

**Items 1-13: Patient and Insured Information**

**Reminder:** For date fields other than date of birth (items 3, 9b, and 11a), all fields shall be either in a 6-digit or an 8-digit format (items 11b, 12, 14, 16, 18, 19, 24a, and 31). Intermixing the two formats on the claim is not allowed.

6-digit: (MM | DD | YY)                      or                      8-digit: (MM | DD | CCYY)

**Item 1** Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

**Item 1a** Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. **This is a required field.**

**Item 2** Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. **This is a required field.**

**Item 3** Enter the patient's eight-digit birth date (MMDDCCYY) and sex.

**Item 4** If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

**Item 5** Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and telephone number.

**Item 6** Check the appropriate box for patient's relationship to insured when Item 4 is completed.

**Item 7** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item **only** when Items 4, 6, and 11 are completed.

**Item 8** Check the appropriate box for the patient's marital status and whether employed or a student.

**Item 9** Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in Item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

**NOTE: Only participating physicians and suppliers are to complete Item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a Medigap policy to the participating physician or supplier.**

Participating physicians and suppliers must enter information required in Item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

**Medigap** - A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in Item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

**Item 9a** Enter the policy and/or group number of the Medigap insured preceded by **MEDIGAP**, **MG**, or **MGAP**. **NOTE:** Item 9d must be completed if the provider enters a policy and/or group number in Item 9a.

**Item 9b** Enter the Medigap insured's eight-digit birth date (MMDDCCYY) and sex.

**Item 9c** Leave blank if a Medigap PayerID is entered in Item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street  
Baltimore, MD 21204

is shown as "1257 Anywhere St. MD 21204."

**Item 9d** Enter the nine-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider of service or supplier **must** accurately complete all of the information in Items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

**Effective October 1, 2007, enter the newly assigned COBA Medigap claim base identifier to trigger the Medigap claim-based crossover**

**Items 10a thru 10c** Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24. Enter the state postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in Item 11.

**Item 10d** Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by **MCD**.

**Item 11 THIS ITEM MUST BE COMPLETED; IT IS A REQUIRED FIELD.**

BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11a - 11c. Items 4, 6, and 7 must also be completed.

**NOTE:** Enter the appropriate information in Item 11c if insurance primary to Medicare is indicated in Item 11.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to Item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to Item 11b.

If a lab has collected previously and retained Medicare secondary payer (MSP) information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in Item 11 of the CMS-1500 form, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

**Insurance Primary to Medicare** - Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage:
  - Working Aged,
  - Disability (Large Group Health Plan), and
  - End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
  - Workers' Compensation,
  - Black Lung, and
  - Veterans Benefits.

**NOTE:** For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

**Item 11a** Enter the insured's eight-digit birth date (MMDDCCYY) and sex, if different from Item 3.

**Item 11b** Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a six-digit (MMDDYY) or eight-digit (MMDDCCYY) retirement date preceded by the word "RETIRED."

**Item 11c** Enter the nine-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. **This is required if there is insurance primary to Medicare that is indicated in Item 11.**

**Item 11d** Leave blank. Not required by Medicare.

**Item 12** The patient or authorized representative must sign and enter either a six-digit date (MMDDYY), eight-digit date (MMDDCCYY), or an alpha-numeric date (e.g., January 1, 1998), unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1 of Pub. 100-04, *Medicare Claims Processing Manual*. If the patient is physically or mentally unable to sign, a representative specified in Chapter 1 may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.

**NOTE:** This can be "Signature on File" and/or a computer generated signature.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.

**Signature by Mark (X)** - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

**Item 13** The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her

authorized representative signs this item or the signature must be on file separately with the provider as an authorization.

The presence of or lack of a signature or “signature on file” in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

**NOTE:** This can be "Signature on File" signature and/or a computer generated signature.

### Items 14-33: Provider of Service or Supplier Information

**Item 14** Enter an eight-digit (MMDDCCYY) or six-digit (MMDDYY) date of current illness, injury, or pregnancy. For chiropractic services, enter an eight-digit (MMDDCCYY) or six-digit (MMDDYY) date of the initiation of the course of treatment and enter an eight-digit (MMDDCCYY) or six-digit (MMDDYY) date in Item 19.

**Item 15** Leave blank. Not required by Medicare.

**Item 16** If the patient is employed and is unable to work in his/her current occupation, enter an eight-digit (MMDDCCYY) or six-digit (MMDDYY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

**Item 17** Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.

**NOTE:** All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate

Form CMS-1500 shall be used for each ordering/referring physician.

**Referring Physician** - A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

**Ordering Physician** - A physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Chapter 15 of Pub. 100-02, *Medicare Benefit Policy Manual*, <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>, for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Social Security Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's NPI. The following services/situations require the submission of the referring/ordering provider information:

- Parenteral and Enteral nutrition
- Immunosuppressive drug claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services; and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and National Provider Identifier (NPI). For example, a surgeon shall complete Item 17b when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned NPI appear in Item 17b.

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned NPI of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in Item 17b.

All physicians who order or refer Medicare beneficiaries or services shall obtain an NPI, even though they may never bill Medicare directly. A physician who has not been assigned an NPI shall contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and NPI of the physician supervising the limited licensed practitioner shall appear in Item 17b.

When a patient is referred to a physician who also orders and performs a diagnostic service, a **separate** claim form is required for the diagnostic service.

- Enter the original ordering/referring physician's name and NPI in item 17b of the first claim form.
- Enter the ordering (performing) physician's name and NPI Items 17 and 17b of the second claim form (the claim for reimbursement for the diagnostic service).

The term "physician," when used within the meaning of §1861(r) of the Social Security Act (the Act) and used in connection with performing any function or action, refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the state in which he/she performs them;
4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act, which he/she is legally authorized to perform as a doctor of optometry by the state in which he/she performs them; or
5. A chiropractor who is licensed as such by a state (or in a state which does not license chiropractors as such) and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

**Item 17a** Effective May 23, 2008, 17a is not to be reported but 17b **MUST** be reported when a service was ordered or referred by a physician.

**Item 17b** Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. *All physicians who order services or refer Medicare beneficiaries must report this data.*

**NOTE:** Effective May 23, 2008, 17a is not to be reported, but 17b **MUST** be reported when a service was ordered or referred by a physician.

**Item 18** Enter either an eight-digit (MMDDCCYY) or a six-digit (MMDDYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

**Item 19** Enter either a six-digit (MMDDYY) or an eight-digit (MMDDCCYY) date patient was last seen and the NPI of his/her attending physician when an independent physical or occupational therapist submits claims or a physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file.

Enter either a six-digit (MMDDYY) or an eight-digit (MMDDCCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination, was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in Item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Chapter 15 of Pub. 100-02, *Medicare Benefits Policy Manual*, <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>, are on file, along with the appropriate x-ray, and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise, an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in Item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows:

1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement, “Homebound,” when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient (see Pub. 100-02, *Medicare Benefits Policy Manual*, Chapter 15, <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> ; Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 16, <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf>); and Pub. 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 5, <http://www.cms.hhs.gov/manuals/downloads/ge101c05.pdf> , respectively, for the definition of “homebound” and a more complete definition of a medically necessary laboratory service to a homebound or an institutionalized patient).

Enter the statement, “Patient refuses to assign benefits,” when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, “Testing for hearing aid,” when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but **only** if Healthcare Common Procedure Coding System (HCPCS) codes do not cover them.

Enter a six-digit (MMDDYY) or an eight-digit (MMDDCCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number “30” for all national emphysema treatment trial claims.

Enter the NPI of the physician who is performing a purchased interpretation of a diagnostic test (see Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 30.2.9.1, <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> , for additional information).

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for end stage renal disease (ESRD) beneficiaries on dialysis (see Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 8, Section 60.7.2, <http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf>).

**Item 20** Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the “yes” block is checked. A “yes” check indicates that an entity other than the entity billing for the service performed the

diagnostic test. A “no” check indicates “no purchased tests are included on the claim.” When “yes” is annotated, Item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a **separate** CMS-1500 form. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.

**NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.**

**Item 21** Enter the patient’s diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the **highest level of specificity for the date of service**. Enter up to four codes in priority order. All narrative diagnoses for non-physician specialties shall be submitted on an attachment.

**Item 22** Leave blank. Not required by Medicare.

**Item 23** Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in a Food and Drug Administration (FDA)-approved clinical trial. Post Market Approval number should also be placed here, when applicable.

For physicians performing care plan oversight services, enter the six-digit Medicare provider number of the home health agency (HHA) or hospice when Current Procedural Terminology (CPT) code G0181 (HH) or G0182 (Hospice) is billed.

Enter the ten-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

**NOTE:** Item 23 can contain **only** one condition. Any additional conditions should be reported on a **separate** CMS-1500 form.

**Item 24a** Enter a six-digit (MMDDYY) or eight-digit (MMDDCCYY) date for each procedure, service, or supply. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column G. **This is a required field.**

**Item 24b** Enter the appropriate place of service code(s) from the list provided later in this chapter. Identify the location, using a place of service code, for each item used or service performed. **This is a required field.**

**NOTE:** When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.

**Item 24c** Medicare providers are not required to complete this item.

**Item 24d** Enter the procedures, services, or supplies using the CMS HCPCS code. When applicable, show HCPCS modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when reporting an “unlisted procedure code” or a NOC code, include a narrative description in Item 19, if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. **This is a required field.**

**Item 24e** Enter the diagnosis code reference number, as shown in Item 21, to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. **This is a required field.**

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in Item 21.

**Item 24f** Enter the charge for each listed service.

**Item 24g** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in Item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see Chapter 20, Section of 130.6 of Pub. 100-04, *Medicare Claims Processing Manual*,  
<http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf>

**NOTE:** This field should contain at least one day or unit.

**Item 24h** Leave blank. Not required by Medicare.

**Item 24i** Leave blank.

**Item 24j** Leave blank.

**Item 25** Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

**Item 26** Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

**Item 27** Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in Item 9 and Medigap payment authorization is given in Item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for **all** covered charges for **all** patients.

The following providers of service/suppliers and claims can **only** be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center (ASC) services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

**Item 28** Enter total charges for the services (i.e., total of **all** charges in Item 24f).

**Item 29** Enter the total amount the patient paid on the covered services **only**.

**Item 30** Leave blank. Not required by Medicare.

**Item 31** Enter the signature of provider of service or supplier, or his/her representative, and either the six-digit date (MMDDYY), eight-digit date (MMDDCCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in Item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in Item 31.

**NOTE: This is a required field**, however, the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file, or if any authorization is attached to the claim, or if the signature field has "Signature on File," and/or a computer generated signature.

**Item 32** Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for **all** services other than those furnished in place of service home - 12.

Effective for claims received on or after April 1, 2004, on the CMS-1500 form, **only** one name, address, and zip code may be entered in the block. If additional entries are needed, **separate** claims forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, ZIP code, and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a **separate** CMS-1500 form should be used to bill for **each** supplier.

For foreign claims, **only** the enrollee can file for Part B benefits rendered outside of the United States. These claims will **not** include a valid zip code. When a claim is received for these services on a beneficiary-submitted CMS-1490S form, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a zip code.

For durable medical, orthotic, and prosthetic claims, the name, address, or NPI of the location where the order was accepted must be entered (**DME MAC only**).

**This field is required.** When more than one supplier is used, a **separate** CMS-1500 form should be used to bill for **each** supplier.

This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the six-digit FDA-approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed and the PIN.

**Item 32a** If required by Medicare claims processing policy, enter the NPI of the service facility.

**Item 32b** Effective May 23, 2008, Item 32b is not to be reported.

**Item 33** Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.**

**Item 33a** Enter the NPI of the billing provider or group. The NPI must be reported on the Form CMS-1500 (08-05) as of May 23, 2008.

**Item 33b** Effective May 23, 2008, Item 33b is not to be reported.

### Place Of Service (POS) Codes And Definitions

The following is the current national POS code set, with facility and non-facility designations noted for Medicare payment for services on the Physician Fee Schedule, as of October 1, 2005. This code set has changed to include a new code for a pharmacy setting, effective October 1, 2005. (**Note:** All of the POS codes listed below are valid under HIPAA.)

(F=Facility, NF=Nonfacility)

Code	Name/Description	Payment Rate
1	<b>Pharmacy</b> A facility or location where drugs and other medically-related items and services are sold, dispensed, or otherwise provided directly to patients.	<b>NF</b>
2	<b>Unassigned</b>	
3	<b>School</b> A facility whose primary purpose is education.	<b>NF</b>
4	<b>Homeless Shelter</b>	<b>NF</b>

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A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

**5 Indian Health Service Free-Standing Facility**  
**(Not applicable for adjudication of Medicare claims.)**

A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.

**6 Indian Health Service Provider-Based Facility**  
**(Not applicable for adjudication of Medicare claims.)**

A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

**7 Tribal 638 Free-Standing Facility**  
**(Not applicable for adjudication of Medicare claims.)**

A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

**8 Tribal 638 Provider-Based Facility**  
**(Not applicable for adjudication of Medicare claims.)**

A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

**9 Prison-Correctional Facility** **NF**  
A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)

**10 Unassigned**

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|----------------|--|-----------|
| <b>11</b>      | <b>Office</b><br>Location, other than a hospital, SNF, military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. | <b>NF</b> |
| <b>12</b>      | <b>Home</b><br>Location, other than a hospital or other facility, where the patient receives care in a private residence.  | <b>NF</b> |
| <b>13</b>      | <b>Assisted Living Facility</b><br>Congregate residential facility with self-contained living units providing assessment of each resident's needs and onsite support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.                        | <b>NF</b> |
| <b>14</b>      | <b>Group Home</b><br>A residence, with shared living areas, where clients receive supervision and other services, such as social and/or behavioral services, custodial services, and minimal services (e.g., medical administration).  | <b>NF</b> |
| <b>15</b>      | <b>Mobile Unit</b><br>A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.   | <b>NF</b> |
| <b>16</b>      | <b>Temporary Lodging (April 1, 2008)</b><br>A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.   | <b>NF</b> |
| <b>17 - 19</b> | <b>Unassigned</b>  |           |
| <b>20</b>      | <b>Urgent Care Facility</b><br>Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.   | <b>NF</b> |
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- 21 Inpatient Hospital F**  
A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under the supervision of, physicians to patients admitted for a variety of medical conditions.
- 22 Outpatient Hospital F**  
A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- 23 Emergency Room - Hospital F**  
A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
- 24 Ambulatory Surgical Center F**  
A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. (Note: Pay at the non-facility rate for payable procedures not on the ASC list.)
- 25 Birthing Center NF**  
A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
- 26 Military Treatment Facility F**  
A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
- 27 - 30 Unassigned**
- 31 Skilled Nursing Facility F**  
A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.



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- 51 Inpatient Psychiatric Facility F**  
A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
- 52 Psychiatric Facility - Partial Hospitalization F**  
A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
- 53 Community Mental Health Center (CMHC) F**  
A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHCs mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour a day emergency care services, day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
- 54 Intermediate Care Facility/Mentally Retarded NF**  
A facility which primarily provides health-related care and services above the level of custodial care to mentally-retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.
- 55 Residential Substance Abuse Treatment Facility NF**  
A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
- 56 Psychiatric Residential Treatment Center F**  
A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically-planned and professionally-staffed group living and learning environment.

- 57 Non-Residential Substance Abuse Treatment Facility NF**  
A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
- 58 - 59 Unassigned**
- 60 Mass Immunization Center NF**  
A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall, but may include a physician office setting.
- 61 Comprehensive Inpatient Rehabilitation Facility F**  
A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
- 62 Comprehensive Outpatient Rehabilitation Facility NF**  
A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
- 63 - 64 Unassigned**
- 65 End-Stage Renal Disease Treatment Facility NF**  
A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
- 66 - 70 Unassigned**

<b>71</b>	<b>State or Local Public Health Clinic</b> A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.	<b>NF</b>
<b>72</b>	<b>Rural Health Clinic</b> A certified facility that is located in a rural medically-underserved area that provides ambulatory primary medical care under the general direction of a physician.	<b>NF</b>
<b>73 - 80</b>	<b>Unassigned</b>	
<b>81</b>	<b>Independent Laboratory</b> A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	<b>NF</b>
<b>82 - 98</b>	<b>Unassigned</b>	
<b>99</b>	<b>Other Place of Service</b> Other place of service not identified above.	<b>NF</b>

## Coordination of Benefits

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, Public Law 101-508) requires **all** Medicare supplemental (Medigap) insurance policies to conform to minimum standards including loss-ratio requirements, standardized benefit packages, and consumer protection requirements. The procedures described in Sections 20 through 110 (Chapter 28 of Pub. 100-04, *Medicare Claims Processing Manual* (<http://www.cms.hhs.gov/manuals/downloads/clm104c28.pdf>)) apply to all policies meeting the definition of Medicare supplemental insurance policies ("Medigap") in Section 1882(g)(1) of the Social Security Act.

The following procedures for furnishing information are mandatory for Medigap plans. Contractors may enter similar arrangements with other insurers or state Medicaid plans for furnishing claims information. Medicaid agencies are furnished information in the standard format free of charge. Other payers must pay Medicare costs for providing information. (**Note:** All automatic crossovers

processed by DME MAC A will be indicated on Medicare remittance advices. If the indication is not present, physicians and suppliers will need to contact the appropriate secondary insurance carrier for resolution.)

A Medicare beneficiary who has a Medigap policy may authorize a participating physician, provider, or supplier of services to file a claim on his/her behalf and to receive payment directly from the insurer instead of through the beneficiary. In such cases, the contractor must transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the physician/provider/supplier and must pay the contractor for its costs in supplying the information, subject to limitations. Paid claims from participating physicians or providers/suppliers for beneficiaries who have assigned their right to payment under a Medigap policy, regardless of whether or not it is in or from a state with an approved Medigap program, are to result in the transfer of claim information to the specified insurer(s).

Beneficiaries indicate that they have assigned their Medigap benefits to a participating physician or supplier by signing Item 13 on the CMS-1500 form. This authorization is in addition to their assignment of Medicare benefits, as indicated by their signature in Item 12. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating Physician/supplier is called a mandated Medigap transfer.

For claim based crossovers participating physicians and suppliers **must** enter information required in Item 9 and its subdivisions (a-d) if requested by the beneficiary. (**Note:** For Item 9d, the PAYERID is referred to as a Coordination of Benefits Agreement (COBA) number. Effective October 1, 2007 Providers should be including **only** the new 5-byte COBA Medigap claim-based ID on incoming Medicare claims for the purpose of triggering crossovers to those Medigap insurers that have been assigned a COBA Medigap claim-based ID that falls in the range of 55000 through 59999. The link to the Medigap Billing ID spreadsheet, which providers or their billing vendors should consult for this purpose, remains as <http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf> on the CMS web site.

(Refer to this list when completing Item 9d.)

**NOTE:** CMS consolidated the claims crossover process, via the Coordination of Benefits Agreement (COBA) initiative, which shifted COB oversight to the Coordination of Benefits Contractor (COBC). For more information on the Medicare COB process, including contacts, visit the CMS Web site at <http://www.cms.hhs.gov/COBGeneralInformation/>.

## Ordering Claim Forms

The CMS-1500 form is the standard claim form used by a physician or supplier to bill Medicare contractors when the physician or supplier qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. For more information, refer to the CMS Web site at

[http://www.cms.hhs.gov/ElectronicBillingEDITrans/07\\_ASCAWaiver.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp)

Physicians and suppliers are responsible for purchasing their own CMS-1500 forms. This form can be bought in single, multi-part snap-out sets, or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house, as long as it follows the CMS-approved specifications developed by the AMA.

Blank forms are **not** distributed by Medicare contractors. In order to purchase claim forms, contact the U.S. Government Printing Office at 202-512-1800, local printing companies in your area, and/or office supply stores. Each of these vendors sells the CMS-1500 form in its various configurations. An electronic sample of the form is available via the CMS Web site, <http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf>. The only acceptable claim forms are those printed in Flint Red, J6983, (or exact match) ink. Photocopied claims should **not** be submitted to Medicare contractors.

**NOTE:** The current version of the CMS-1500 form has been revised to accommodate the reporting of the NPI, effective January 1, 2007, and is required for claim submissions on July 2, 2007.