NHIC, Corp.

A CMS Contractor

Medicare Part B Contractor - ISO 9001:2000 Certified
Durable Medical Equipment Medicare Administrative Contractor

DME MAC Jurisdiction A

Interactive CMS 1500 Form

2009 Edition (October)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES 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? YES NO *If yes*, return to and complete item 9 a-d.

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 ____________ 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 ____________

PATIENT AND INSURED INFORMATION

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

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____

2. ____ . ____

3. ____ . ____

4. ____ . ____

22. MEDICAID 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. 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.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

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.

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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.**

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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.**

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Item 3

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

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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 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.

Back to Form

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.

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Item 6

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

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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.

Back to Form

Item 8

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

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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.

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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.*

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Item 9b

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

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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 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."

Back to Form

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.

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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.

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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**.

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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.*

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Item 11a

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

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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 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."

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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 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.**

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Item 11d

Leave blank. Not required by Medicare.

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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.

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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 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.*

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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.

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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 15

Leave blank. Not required by Medicare.

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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.

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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 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.

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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.

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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.*

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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.

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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 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 institutional 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).

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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 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.*

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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.

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Item 22

Leave blank. Not required by Medicare.

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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.*

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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.**

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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 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.*

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Item 24c

Medicare providers are not required to complete this item.

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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.**

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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.

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Item 24f

Enter the charge for each listed service.

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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.*

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Item 24h

Leave blank. Not required by Medicare.

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Item 24i

Leave blank.

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Item 24j

Leave blank.

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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.

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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.

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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.

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Item 28

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

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Item 29

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

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Item 30

Leave blank. Not required by Medicare.

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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.*

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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 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.

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Item 32a

If required by Medicare claims processing policy, enter the NPI of the service facility.

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Item 32b

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

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Item 33

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

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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.

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Item 33b

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

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