

CMS-1500 Claim Form Instructions – Set C

The form below includes directions for compatible provider types. Please follow the instructions in your provider-type column.

Provider Type KEY: R = Required O = Optional N = No Entry needed			Home & Community- Based Agency	Environmental Modifications	Chiropractic Service	Hearing Service	Independent Lab Services	Vision Services	X-ray Services
Field	Field ID	Instructions							
1.	Medicaid	Required. All providers are to select Medicaid.	R	R	R	R	R	R	R
1a.	Insured's ID #	Required. Enter the patient's 10-digit Medical Assistance ID number.	R	R	R	R	R	R	R
2.	Patient's Name	Required. Enter the following information as it appears on the eligibility form: patient's full last name, first name and middle initial.	R	R	R	R	R	R	R
3.	Patient's Birth Date/Sex	Optional. If used, enter patient's date of birth in MM/DD/YY format and check box "M" or "F" to indicate sex.	O	O	O	O	O	O	O
4.	Insured's Name	No entry needed.	N	N	N	N	N	N	N
5.	Patient's Address	Optional. If used, enter patient's full street address, city, state, and ZIP code.	O	O	O	O	O	O	O
6.	Patient's Relationship to Insured	Required. Select Self.	R	R	R	R	R	R	R
7.	Insured's Address	No entry needed.	N	N	N	N	N	N	N
8.	Patient Status	Optional. Select the appropriate box.	O	O	O	O	O	O	O
9.-9d.	Other Insured's Name a. Other Insured's Policy or Group Number b. Other Insured's DOB & Sex c. Employer's Name or School Name d. Insurance Plan or Program Name	Required. If the patient has other insurance, as indicated in field 11d., enter the name of the policyholder, plan name, address and policy number.	R	R	R	R	R	R	R
10.	Is Patient's Condition related to: a. Employment <input type="checkbox"/> b. Auto Accident <input type="checkbox"/> c. Other Accident <input type="checkbox"/>	Required, if applicable. Select the appropriate box and indicate in what state the accident occurred.	R	R	R	R	R	R	R
10d.	Reserved For Local Use	No entry needed.	N	N	N	N	N	N	N

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11.	Insured's Policy Group or FECA # a. Insured's DOB & Sex b. Employer's Name or School's Name c. Insurance Plan or Program Name	No entry needed, but if used enter patient's DOB in MM/DD/YY.	N	N	N	N	N	N	N
11d.	Is There Another Health Benefit Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	Required. Select the appropriate box. If "yes," complete fields 9-9d.	R	R	R	R	R	R	R
12.-13.	Patient's or Authorized Person's Signature for Release of Medical Info.	Optional. Appropriate individuals must sign or indicate if signature is on file (SOF).	O	O	O	O	O	O	O
14.	Date of Current Illness or Injury or Pregnancy	Optional. If used, enter the date on which diagnosis was made.	O	O	O	O	O	O	O
15.-16.	If Patient Has Had Same or Similar Illness, give First Date/s Patient was Unable to Work in Current Occupation	Optional. If used, enter the date on which diagnosis was made.	O	O	O	O	O	O	O
17.	Name of Referring Physician/Other Source	Required, during NPI contingency period, if applicable. Enter name of provider who referred patient for services.	R	R	R	R	R	R	R
17a.	Non-NPI ID	Required, during NPI contingency period, if applicable. Enter the two-digit qualifier identifying the Non-NPI number immediately to the right of 17a. (first field). Qualifier ID is used when submitting Medicaid Provider IDs. For a complete listing of the approved two-digit qualifiers, refer to the NUCC Website: www.nucc.org . Enter the non-NPI number of the referring, ordering, or supervising provider (second field). This number should either be the provider's Medicaid Provider ID or the taxonomy code based on the correlating identifying qualifier in the first field of 17a. During NPI dual usage period, the Medicaid Provider ID is required.	R	R	R	R	R	R	R
17b.	ID Number of Referring Physician	Required. Enter the NPI of the referring, ordering, or supervising provider.	R	R	R	R	R	R	R

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18.	Hospitalization Dates Related to Current Services	No entry needed.	N	N	N	N	N	N	N
19.	Reserved for Local Use	No entry needed.	N	N	N	N	N	N	N
20.	Outside Lab?	No entry needed. Alaska Medicaid rules require separate enrollment of labs.	N	N	N	N	N	N	N
21.	Diagnosis or Nature of Illness or Injury	Required. Enter the ICD-9-CM diagnosis codes that describe the sign, symptom, complaint, or condition of the patient that applies to the procedure(s) performed or service(s) supplied.	N	N	R	R	R	R	R
22.	Medicaid Resubmission Code	No entry needed.	N	N	N	N	N	N	N
23.	Prior Authorization Number	Required, if applicable. If any services billed on the claim form have been authorized prior to the services being supplied, enter the eight-digit prior authorization code.	R	R	R	R	R	R	R
24A.- G.	Supplemental Information	Required, if applicable. In the <u>shaded</u> area, enter supplemental information to support the billed service or to explain unusual circumstances. Example 1: If the patient was a Nursing Home Resident, enter two spaces and value "LTC" in the <u>shaded</u> area. Example 2: If the service billed in the <u>unshaded</u> area is a drug code (usually J code), enter the qualifier "N4" followed by the National Drug Code (NDC) that corresponds to the code submitted in the <u>unshaded</u> area (i.e., "N400026064871" is entered in the <u>shaded</u> area when code "J1563" is entered in the <u>unshaded</u> area). Example 3: When submitting the NDC in 24D and the NDC and HCPCS units are not the same, enter the applicable NDC-related units in the <u>shaded</u> area. Refer to the NUCC website: www.nucc.org for more examples of entering supplemental information.							
24A.	Dates of Service	Required. To bill for NDC codes - In the <u>shaded</u> area, enter qualifier 'N4' and the 11 digit NDC number. (Do not enter hyphens or spaces within the NDC number.) In the <u>unshaded</u> area, enter the "from" and "to" dates services were rendered in MM/DD/YY format. The six-digit format is preferred; however the eight-digit format is also acceptable, such as MM/DD/CCYY. Each service/procedure must be entered on a separate line with no more than six lines per form.	R	R	R	R	R	R	R

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24B.	Place of Service	Required. In the <u>unshaded</u> area, enter the place of service by using the two-character national code that reflects where service was rendered. Codes can be found at http://cms.hhs.gov/PlaceofServiceCodes/ .	R	R	R	R	R	R	R
24C.	EMG (emergency indicator)	Required, if applicable. In the <u>unshaded</u> area, enter a "Y" if services are an emergency, otherwise leave blank.	R	R	R	R	R	R	R
24D.	Procedures, Medical Services or Supplies	Required. To bill for NDC codes - In the <u>shaded</u> area, enter the NDC unit of measure (2 positions) immediately followed by the numeric quantity administered to the patient. (Enter the actual metric decimal quantity (units) administered. The quantity field is limited to 9 bytes in the format 99999.999. Enter the quantity from left to right. Enter the decimal point. Leave spaces at the end of the field. The valid unit of measurement codes are F2=International Unit, GR=Gram, ML=Milliliter, and UN=Unit. In the <u>unshaded</u> area, enter the appropriate procedure codes and modifiers. If appropriate, enter up to four sets of two character modifiers.	R	R	R	R	R	R	R
24E.	Diagnosis Pointer	Required. In the <u>unshaded</u> area, enter the item number (1-4) of the diagnosis code from Field 21 (Diagnosis or Nature of Illness or Injury) that applies to the procedure(s) performed or the service(s) supplied.	N	N	R	R	R	R	R
24F.	\$ Charges	Required. Leave the <u>shaded</u> area blank. In <u>unshaded</u> area, enter charges. Enter your actual fee for the services. Whole dollars are entered to the left of the vertical line; cents are entered on right of vertical line. If billing more than one unit of a service, the figure entered in this field reflects the total fee for all the units billed on this claim line.	R	R	R	R	R	R	R
24G.	Days or Units	Required. In the <u>shaded</u> area, enter 'LTC' if the recipient is in a long term care facility. In the <u>unshaded</u> area, enter the number of units appropriate to the services rendered.	R	R	R	R	R	R	R

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24H.	EPSDT/Family Planning	<p>Required. In order to exempt your EPSDT patients from paying a cost sharing amount, Field 24H must be filled in. Failure to indicate a code in this field may result in a cost sharing amount being deducted from the amount reimbursed to the provider. Enter the response in the <u>shaded</u> area of the field as follows: Y for "Yes" or N for "No."</p> <p>Required. For Family Planning, enter the response in the <u>unshaded</u> area of the field as follows: Y for "Yes" or N for "No."</p>	N	N	R	R	R	R	R
24I.	ID Qualifier	<p>Required, if applicable. In the <u>shaded</u> area, enter the two-digit qualifier identifying the Non-NPI number. Enter the Medicaid Provider ID. For a complete listing of the approved two-digit qualifiers, refer to the NUCC website: www.nucc.org. During NPI dual usage period, the Medicaid Provider ID is required.</p>	R	R	R	R	R	R	R
24J.	Rendering Provider ID#	<p>Required. Rendering Provider is the person or company (lab or other facility that rendered or supervised the care). In the <u>shaded</u> area, enter the provider's Medicaid Provider ID if qualifier "ID" was entered in Field 24I. Enter provider's taxonomy code if "ZZ" was entered in Field 24I. Where a locum tenens was used, enter that provider's information here. In the <u>unshaded</u> area, enter the rendering provider's NPI.</p>	O	O	R	R	O	R	O
25.	Federal Tax ID #	<p>Optional. Enter the tax ID number of the billing provider.</p>	O	O	O	O	O	O	O
26.	Your Patient's Account #	<p>Optional. This is for the convenience of the provider for identifying the claim on the Remittance Advice.</p>	O	O	O	O	O	O	O
27.	Accept Assignment?	<p>Required. If applicable, select the appropriate box. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	N	N	R	R	R	R	R
28.	Total Charge	<p>Required. Enter the total for all charges listed in Column 24F.</p>	R	R	R	R	R	R	R
29.	Amount Paid	<p>Required. If applicable, enter the amount paid by any insurance carrier, legal settlement or recipient Cost of Care Amount - COCA. Attach the Explanation of Benefits (EOB) for this paid amount.</p>	R	R	R	R	R	R	R

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30.	Balance Due	Required , if Field 29 is used. Enter difference of Field 28 and Field 29.	R	R	R	R	R	R	R
31.	Signature of Physician or Supplier Including Degree or Credentials	Required . The claim must be signed and dated by the health care provider or an assigned representative or indicating if signature on file (SOF). A facsimile signature is NOT acceptable. The claim cannot be prepared and signed/dated prior to the dates of services being rendered. The signature date becomes the billing date and must not be a future date or date before the latest date of service on the claim.	R	R	R	R	R	R	R
32.	Service Facility Location Information	Optional . Enter the name and address of the location where services were provided. Include ZIP Code+4. This is used in NPI matching.	O	O	O	O	O	O	O
32a.	Service Facility NPI	Optional . Enter National Provider ID in <u>unshaded</u> area.	O	O	O	O	O	O	O
32b.	Service Facility Non-NPI Number	Optional . Enter the two-digit qualifier identifying the Non-NPI number of the billing provider followed by the provider's Medicaid Provider ID or taxonomy code based on the correlating identifying qualifier in the <u>shaded</u> area.	O	O	O	O	O	O	O
33.	Billing Provider's Information & Phone Number	Required . Enter the following information as shown on your Medical Assistance Provider Agreement: name, street address, city/state, ZIP Code+4, and telephone.	R	R	R	R	R	R	R
33a.	Billing NPI	Required . Enter National Provider ID for the billing provider in the <u>unshaded</u> area.	R	N	R	R	R	R	R
33b.	Billing Medicaid Provider ID	Required . Enter the two-digit qualifier identifying the Non-NPI number of the billing provider followed by the provider's Medicaid Provider ID or taxonomy code based on the correlating identifying qualifier in the <u>shaded</u> area. During NPI dual usage period, the Medicaid Provider ID is required. Example: 1DMD1234.	R	R	R	R	R	R	R