RMD Bulletin

Knowledge is power…

GUIDE TO COMPLETING THE CMS 1500 FORM

The Centers for Medicare & Medicaid Services (CMS), CMS-1500 Form, is a pre-printed red and white universal claim form used by health care providers, including all contract providers, to submit claims for services to insurance carriers. The claim form was redesigned in 2005 to allow the reporting of the National Provider Identifier (NPI).

It is very important that the CMS-1500 form be completed properly to ensure that the insurance company accepts the claim. Each insurance carrier may have specific requirements or instructions for completing the CMS-1500, however all payers require the form to be **typed**. Providers should contact insurance carriers to ensure that claims are compliant with the requirements of the specific carrier. If the form is not completed properly, the claim may be denied by the insurance carrier. Payments will be mailed to the address typed on Box 33 of the CMS-1500 form.

Please note that there are very specific instructions related to the use of punctuation for certain fields in the Instruction column of the attached guide. You must follow these instructions when completing the CMS-1500 claim form.

Attached are a completed sample and a desk reference for the CMS-1500 form with columns for Item #, Title, Instruction and Field Contents. (The sample CMS-1500 form is only to display how the fields should be filled in.) Fields 9, 9a-9d, 10d, 15, 16, 17, 17a-17b, 18, 19, 20, 22, 23, 29 and 30 are "not applicable" and do not need to be completed. However, keep in mind that if the insurance company requires these fields to be completed, providers should follow the instructions provided by the company. Additional detailed instructions on completing the CMS-1500 claim form can be found at http://www.nucc.org/. Click on the "1500 Claim Form" link found in the header of the National Uniform Claim Committee (NUCC) website.

The CMS-1500 Form (08-05) is stocked in the Department of Mental Health (DMH) warehouse. Simply submit your order by mail or at the warehouse on agency letterhead to DMH, Attention: Administrative Support Bureau (ASB), 550 South Vermont Avenue, 2nd Floor, Los Angeles, California, 90020.

To assure availability of the CMS-1500 (08-05) form in DMH's warehouse supply, your order will be limited to one package. One package contains 500 sheets of the 1500 health insurance claim form.

We're here to help you…

If you have any questions or require further information, please contact RMD at (213) 480-3444 or e-mail RevenueManagement@dmh.lacounty.gov.

DOES NOT APPLY TO FEE-FOR-SERVICE PROVIDERS

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): X0123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE JR, JOHN
3. PATIENT'S BIRTH DATE MM DD YY: 01 01 87 — SEX: M ☒ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE JR, JOHN
5. PATIENT'S ADDRESS (No., Street): 123 ANY STREET
6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street): 123 ANY STREET
CITY: ANYTOWN — STATE: CA
8. PATIENT STATUS: Single ☒ Married ☐ Other ☐; Employed ☒ Full-Time Student ☐ Part-Time Student ☐
CITY: ANYTOWN — STATE: CA
ZIP CODE: 90610 — TELEPHONE (Include Area Code): (312) 5551212
ZIP CODE: 90610 — TELEPHONE (Include Area Code): (312) 5551212
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: ABC INSURANCE COMPANY
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: SIGNATURE ON FILE — 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: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — MM DD YY: 01 01 05
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.
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. 995 . 5
2. 780 . 09
3. 290 . 10
4. 332 . 1
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												Z5678901234
	01 01 05	01 01 05	11		90899		1234	50 00	1		NPI	9876543210
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 123456789 — SSN ☐ EIN ☒
26. PATIENT'S ACCOUNT NO.: 12341234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES ☐ NO ☐
28. TOTAL CHARGE: $ 50 00
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.)
JOHN SMITH, MD — 01/02/2005
SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION
HWR Mental Health Clinic
9876 Any Street
Anytown CA 91610-9876
a. NPI — b.

33. BILLING PROVIDER INFO & PH # (123) 5551234
General Mental Health Program
12345 Pico Blvd 400
Los Angeles CA 90015
a. 1236547890 — b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE ONLY

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
1	Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.	"Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, or Other" means the insurance type to whom the claim is being submitted. Other indicates health insurance including HMOs, commercial insurance, automobile accident, liability, or workers' compensation. This information directs the claim to the correct program and may establish primary liability.
1a	INSURED'S ID NUMBER	Enter insured's ID number as shown on insured's ID card for the payer to whom the claim is being submitted.	The "Insured's ID Number" is the identification number of the insured. This information identifies the insured to the payer. Typically numeric or alpha numeric.
2	PATIENT'S NAME	Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Do not use punctuation of any kind.	The "Patient's Name" is the name of the person who received the treatment or supplies.
3	PATIENT'S BIRTH DATE, SEX	Enter the patient's 8-digit birth date (MMDDCCYY). Enter an X in the correct box to indicate sex of the patient. Only one box can be marked. If gender is unknown, leave blank.	The "Patient's Birth Date, Sex" (gender) is information that will identify the patient and it distinguishes persons with similar names.
4	INSURED'S NAME	Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Do not use punctuation of any kind.	The "Insured's Name" identifies the person who holds the policy, which would be the employee for employer-provided health insurance.
5	PATIENT'S ADDRESS	Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number. Enter "Homeless" if the patient is homeless.	The "Patient's Address" refers to the patient's permanent residence. A temporary address or school address should not be used.
6	PATIENT RELATIONSHIP TO INSURED	Enter an X in the correct box to indicate the patient's relationship to insured.	This field allows for entry of 1 character in any box within the field.

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
7	INSURED'S ADDRESS	Enter the insured's address and telephone number. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.	The "Insured's Address" refers to the insured's permanent residence, which may be different from the patient's address in Item Number 5.
8	PATIENT STATUS	Enter an X in the box for the patient's marital status (Single/Married/Other). For the patient's employment or student status (Employed/Full-Time Student/Part-Time Student), enter an X in the box if applicable, if not leave blank. Only one box on each line can be marked.	This field allows for entry of 1 (one) character in any box within the field.
9	OTHER INSURED'S NAME	If indicated on Box 11d as "YES," 9a - 9d must be filled out. Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Do not use punctuation of any kind.	This field allows for the entry of 28 characters.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number.	This field allows for the entry of 28 characters.
9b	OTHER INSURED'S DATE OF BIRTH AND SEX	"Other Insured's Date of Birth, Sex" does not exist in 4010A1 or 5010A1. The NUCC recommends that this field not be used. If required by payer to report, enter the 8-digit date of birth MM DD CCYY of the other insured and an X to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.	This field allows for the entry of the following: 2 characters under MM, 2 characters under DD, 4 characters under YY, and 1 character in either box.
9c	EMPLOYER'S NAME OR SCHOOL NAME	"Employer's Name or School Name" does not exist in 4010A1 or 5010A1. The NUCC recommends that this field not be used. If required by a payer to report, enter the name of the other insured's employer or school.	This field allows for the entry of 28 characters.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Enter the other insured's insurance plan or program name.	This field allows for the entry of 28 characters.

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
10a-c	IS PATIENT'S CONDITION RELATED TO:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code must be shown if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.	This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. "Employment" (current or previous) would indicate that the condition is related to the patient's job or workplace. "Auto Accident" would indicate that the condition is the result of an automobile accident. "Other Accident" would indicate that the condition is the result of any other type of accident.
10d	RESERVED FOR LOCAL USE	N/A	
11	INSURED'S POLICY GROUP OR FEDERAL EMPLOYEES' COMPENSATION ACT (FECA) NUMBER	Enter the insured's policy group or FECA number as it appears on the insured's health care identification card. The FECA number is the 9-digit alphanumeric identifier assigned to patients claiming a work related condition. If Item Number 4 is completed, then this field should be completed.	The "Insured's Policy, Group, or FECA Number" refers to the alphanumeric identifier for the health, auto, or other insurance plan coverage. For worker's compensation claims the workers compensation carrier's alphanumeric identifier would be used. The FECA number is the 9-digit alphanumeric identifier assigned to a patient's claiming work-related condition(s) under the Federal Employees' Compensation Act 5 USC 8101.
11a	INSURED'S DATE OF BIRTH AND SEX.	Enter the 8-digit date of birth (MMDDCCYY) of the insured and an X to indicate the sex of the insured. Only one box can be marked. If gender is unknown, leave blank.	The "Insured's Date of Birth, Sex" (gender) refers to the birth date and gender of the insured as indicated in Item Number 1a.
11b	INSURED'S EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of the insured's employer or school.	The insured's "Employer's Name or School Name" refers to the name of the employer or school attended by the insured as indicated in Item Number 1a.
11c	INSURANCE PLAN OR PROGRAM NAME	Enter the insurance plan or program name of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.	The "Insurance Plan Name or Program Name" refers to the name of the plan or program of the insured as indicated in Item Number 1a.

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When appropriate, enter an X in the correct box. If marked "YES," complete 9 and 9a-d. Only one box can be marked.	"Is there another health benefit plan?" Indicates that the patient has insurance coverage other than the plan indicated in Item Number 1.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	The recipient's signature or the words "**SIGNATURE ON FILE**" must appear in this field. (The words "signature on file" can only be used when an Insurance Authorization and Assignment of Benefits form (Supplement A-4) has been signed by the insured. Insurance Authorization form can be found on RMD's intranet website under the link titled "RMD Forms." When the recipient's signature is used, enter the date of signature in 6 digit (MMDDYY) or 8 digit (MMDDCCYY).	The "Patient's or Authorized Person's Signature" indicates that the client has athorization or that there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	If the Insured or Authorized person is present and wishes to sign, they may do so; if not enter, "SIGNATURE ON FILE."	The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits.
14	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	Enter the 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.	The "Date of Current Illness, Injury, Pregnancy" refers to the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVEN FIRST DATE	N/A	
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	N/A	
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	N/A	
17a	OTHER ID#	N/A	
17b	NPI#	N/A	
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	N/A	
19	RESERVED FOR LOCAL USE	N/A	

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
20	OUTSIDE LAB? ▫ YES ▫ NO AND $ CHARGES	N/A	
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the patient's diagnosis/condition. List no more than four DSM IV diagnosis codes. Refer to each diagnosis by its line number. Relate lines 1, 2, 3, 4 to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this field. Refer to the Integrated System Codes Manual.	The "Diagnosis or Nature of Illness or Injury" refers to the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.
22	MEDICAID RESUBMISSION AND/OR ORIGINAL REFERENCE #	N/A	
23	PRIOR AUTHORIZATION #	N/A	
24a	DATE(S) OF SERVICE	Enter the beginning and end date(s) of service. If one date of service only, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G.	"Date(s) of Service" indicate the actual month, day, and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.
24b	PLACE OF SERVICE	In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website_POS_database.pdf**	The "Place of Service" Code identifies the location where the service was rendered.
24c	EMG (LINES 1-6)	Check with insurance carrier to determine if this element (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field.	

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
24d	PROCEDURES, SERVICES, OR SUPPLIES	Enter the CPT or HCPCS code(s) (procedure codes) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description. The two-digit modifiers are not used for billing private insurance.	The "Procedures, Services or Supplies" refer to a listing of identifying codes for reporting medical services and procedures.
24e	THE DIAGNOSIS POINTER	In 24E, enter the diagnosis code reference number (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple diagnoses are related to one service, the reference number for the primary diagnosis should be listed first, other applicable diagnosis reference numbers should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4, or multiple numbers as explained. (DSM IV diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.) Do not use commas between pointers.	The "Diagnosis Pointer" refers to the line number from Item Number 21 that relates to the reason the service(s) was performed.
24f	CHARGES	Enter the charge for each listed service. Calculate the $ Charges by using the proper published charge rate multiplied by the units of service.	"$ Charges" refers to the total billed amount for each service line.
24g	DAYS OR UNITS OF SERVICE	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. When calling for prior authorization, ask the representative if they require units of service, increments of 15 minutes, or per visist as it various by carrier.	Days or Units
24h	EPSDT/FAMILY PLAN (LINES 1-6)	For Early and Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: If there is no requirement (e.g., state requirement) to report a reason code for EPSDT, enter Y for "YES" or N for "NO" only. Ask the insurance company for instruction when calling for authorization.	The "EPSDT/Family Plan" identifies certain services that may be covered under some state plans.

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
24i	ID QUALIFIER (LINES 1-6)	Enter in the shaded area of 24I the qualifier identifying if the number is a non National Provider Identifier (NPI). The other ID# of the rendering provider is reported in 24j in the shaded area.	If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24j	RENDERING PROVIDER ID# AND NPI#	In the shaded portion of box 24j, enter the Medicare or other payer's assigned care legacy number and in the lower unshaded portion of box 24j enter the rendering provider's NPI number. If clinician is unlicensed, enter the taxonomy in the shaded portion of 24j instead of the legacy number.	The non-NPI ID number of the rendering provider refers to the unique identifier of the professional or to the provider designated taxonomy code.
25	FEDERAL TAX I.D. NUMBER	Enter the Federal Tax I.D. Number (employer identification number or Social Security number) of the Billing Provider identified in Item Number 33. This is the tax I.D. number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Do not use a hyphen in the Tax I.D.	The "Federal Tax I.D. Number" refers to the unique identifier assigned by a federal or state agency.
26	PATIENT'S ACCOUNT NO.	Enter the patient's account number (IS Client I.D. number) assigned by the provider of service's or supplier's accounting system.	The "Patient's Account No." refers to the identifier assigned by the provider.
27	ACCEPT ASSIGNMENT	The accept assignment indicates that the rendering provider agrees to accept assignment under the terms of the Medicare Program. Check "Yes" if the provider is enrolled as a Medicare Provider; check "No" if the provider is not a Medicare Provider. Only one box can be marked. Ask the private insurance company if they need this box to be checked on the claim form.	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	TOTAL CHARGE	The total charge indicates the total billed amount for all services entered in 24F (lines 1-6).	The "Total Charge" indicates the total billed amount for all services entered in 24F (lines 1–6).
29	AMOUNT PAID	N/A	
30	BALANCE DUE	N/A	

GUIDE TO COMPLETING THE CMS-1500 FORM

Item #	Title	Instruction	Field Contents
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Enter the authorized or accountable person's name and the degrees, credentials or title and date the form was signed. Enter "SIGNATURE ON FILE" in front of SIGNED.	The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.
32	SERVICE FACILITY LOCATION INFORMATION	Enter the name, address, city, state, and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, zip code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. Enter a space between town name and state code; do not include a comma. When entering a 9-digit ZIP code, include the hyphen.	The name and address of facility where services were rendered identifies the site where service(s) were provided.
32a	NPI#	Enter the NPI number of the service facility location in 32a.	The NPI number refers to the nationally recognized HIPAA health provider identifier for the location.
32b	Other ID#	Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	The non-NPI number of the service facility refers to the unique identifier of the professional or to the provider designated taxonomy code.
33	BILLING PROVIDER INFO AND PHONE NUMBER	Enter the provider's or supplier's billing name, address, zip code, and phone number. Do not use punctuation (commas, periods) or other symbols in the address (123 N Main Street 101 instead of 123 N. Main Street, #101) Telephone number to be entered in the upper right hand corner of the field should be providers' main telephone number for their program. Do not use hyphens in the telephone number.	The billing provider's or supplier's billing name, address, zip code, and phone number refers to the billing office location and telephone number of the provider or supplier.
33a	NPI OF THE BILLING PROVIDER	The NPI number refers to the National Provider Identifier Number. Contract providers should use their own NPI.	The NPI number refers to the nationally recognized HIPAA health provider identifier for the location.
33b	Other ID#	Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and the number.	The non-NPI number of the billing provider refers to the unique identifier of the provider or to the provider designated taxonomy code.