# RMD Bulletin

**Knowledge is power…**

# COMPLETING THE CMS-1500 FORM

The Centers for Medicare and Medicaid Services (CMS) generates the CMS-1500 Health Insurance Claim Form, formerly known as the Health Care Financing Administration (HCFA) 1500 form. The claim form was redesigned in 2005 to allow the reporting of the National Provider Identifier (NPI). It's a pre-printed red and white universal claim form used by health care providers to submit claims for services to insurance carriers.

Contract providers are to use the CMS-1500 form to bill private insurance. 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. Providers should contact insurance carriers to make sure the claim completeness meets the company's requirements. If the form is not completed properly, the claim may be denied by the insurance carrier.

Below is a table listing the required fields on the CMS-1500 form and an explanation describing what generally goes into each of the required fields. 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.

| Item # | Required Items | Explanation |
|---|---|---|
| 1 | INDICATE INSURANCE TYPE | 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. |
| 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. |
| 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. |

| Item # | Required Items | Explanation |
|---|---|---|
| 3 | PATIENT'S BIRTH DATE, SEX | Enter the patient's 8-digit birth date (MM \| DD \| CCYY). 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. |
| 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. |
| 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. |
| 6 | PATIENT RELATIONSHIP TO INSURED | Enter an X in the correct box to indicate the patient's relationship to insured. |
| 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. |
| 8 | PATIENT STATUS | Enter an X in the box for the patient's marital status, and for the patient's employment or student status. Only one box on each line can be marked. |
| 9 | OTHER INSURED'S NAME | N/A |
| 9a | OTHER INSURED'S POLICY OR GROUP NUMBER | N/A |
| 9b | OTHER INSURED'S DATE OF BIRTH AND SEX | N/A |
| 9c | EMPLOYER'S NAME OR SCHOOL NAME | N/A |
| 9d | INSURANCE PLAN NAME OR PROGRAM NAME | N/A |
| 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.<br><br>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. |

| Item # | Required Items | Explanation |
|---|---|---|
| 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 patient claiming a work related condition. If Item Number 4 is completed, then this field should be completed. |
| 11a | INSURED'S DATE OF BIRTH AND SEX. | Enter the 8-digit date of birth (MM \| DD \| CCYY) 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. |
| 11b | INSURED'S EMPLOYER'S NAME OR SCHOOL NAME | Enter the name of the insured's employer or school. |
| 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. |
| 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. |
| 12 | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File", "SOF", or legal signature. When legal signature, enter date signed in 6 digit format or 8 digit format, when there is an authorization on file. If there is no signature on file, leave blank or enter "No Signature on File". |
| 13 | INSURED'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Please see attachment." |
| 14 | DATE OF CURRENT ILLNESS, INJURY, PREGNANCY | Enter the 6-digit (MM \| DD \| YY) or 8-digit (MM \| DD \| CCYY) 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. |
| 15 | IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS | 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 |
| 20 | OUTSIDE LAB? ◻ YES ◻ NO AND $ CHARGES | N/A |

| Item # | Required Items | Explanation |
|---|---|---|
| 21 | DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Enter the patient's diagnosis/condition. List no more than four ICD-9-CM diagnosis codes. 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. |
| 22 | MEDICAID RESUBMISSION AND/OR ORIGINAL REFERENCE # | N/A |
| 23 | PRIOR AUTHORIZATION # | N/A |
| 24a | DATE(S) OF SERVICE | Enter date(s) of service, from and to. 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. |
| 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/PlaceofServiceCodes/Downloads/posdatabase110509.pdf. |
| 24c | EMG (LINES 1-6) | Check with insurance company 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. |
| 24d | PROCEDURES, SERVICES, OR SUPPLIES | Enter the CPT or HCPCS code(s) 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. |
| 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. (ICD-9-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.) |
| 24f | CHARGES | Enter the charge for each listed service. |

| Item # | Required Items | Explanation |
|---|---|---|
| 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. If only one service is performed, the numeral 1 must be entered. |
| 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. |
| 24i | ID QUALIFIER (LINES 1-6) | Enter in the shaded area of 24I the qualifier identifying if the number is a non NPI. The other ID# of the rendering provider is reported in 24j in the shaded area. |
| 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. |
| 25 | FEDERAL TAX I.D. NUMBER | Enter the Federal Tax ID Number (employer identification number or Social Security number) of the Billing Provider identified in Item Number 33. This is the tax ID 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. |
| 26 | PATIENT'S ACCOUNT NO. | Enter the patient's account number assigned by the provider of service's or supplier's accounting system. |
| 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. |
| 28 | TOTAL CHARGE | 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 |
| 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. (for example, John Smith MD 09/30/08.) |

| Item # | Required Items | Explanation |
|---|---|---|
| 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. |
| 32a | NPI# | Enter the NPI number of the service facility location in 32a. |
| 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. |
| 33 | BILLING PROVIDER INFO AND PHONE NUMBER | Enter the provider's or supplier's billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st Line-Name; 2nd Line-Address; 3rd Line- City, State, and Zip Code. |
| 33a | NPI OF THE BILLING PROVIDER | The NPI number refers to the National Provider Identifier Number. |
| 33b | Other ID# | Enter the two digit qualifier indentifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and the number. |

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.

The CMS-1500 Form (08-05) is stocked in the Department of Mental Health (DMH) warehouse. Simply submit your form order 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.