CMS 1500 InstaGuide

1500

HEALTH INSURANCE CLAIM FORM

National Uniform Claim Committee (NUCC) Instructions

1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12

Version 10.0 7/22

CMS/Medicare Instructions

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

(Rev. 11037, 05-27-22)

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About this Manual

The *InstaGuide to the 1500 Health Insurance Claim Form* is a convenient compilation of the official instructions from the National Uniform Claim Committee (NUCC) and the Medicare Claims Processing Manual, Chapter 26, by the Centers for Medicare and Medicaid Services (CMS).

We are pleased to publish this specialized reference manual for practitioners and payers. It can help practitioners and payers with better communication tools to expedite claim processing. Although the focus of the official instructions is on the paper 1500 Health Insurance Claim Form, the same basic principles also apply to electronic claims. Readers will note references to “electronic claims” throughout the these instructions.

Acknowledgments

Development of this annual edition requires extensive review and input. The contributions over many years from numerous physicians, assistants, consultants, and attorneys have made this book possible. Their efforts and professional input are sincerely appreciated but they are too numerous to list here. Special thanks also goes to all of the hardworking innoviHealth support staff.

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Special thanks to our third-party partners and reviewers

Table of Contents

Table of Contents (continued)

Introduction

Background Information

The 1500 Health Insurance Claim Form (1500 Claim Form) answers the needs of many health care payers. It is the basic paper claim form prescribed by many payers for claims submitted by physicians, other providers, and suppliers, and in some cases, for ambulance services.

In the 1960s, there were a number of different claim forms and coding systems required by third-party payers to communicate information regarding procedures and services to agencies concerned with insurance claims. There was, however, no standardized form for physicians and other health care providers to report health care services. Therefore, the American Medical Association (AMA) embraced an assignment in the 1980s to work with the Centers for Medicare & Medicaid Services (CMS; formerly known as HCFA), and many other payer organizations through a group called the Uniform Claim Form Task Force to standardize and promote the use of a universal health claim form. As a result of this joint effort, the 1500 Claim Form is accepted nationwide by most insurance entities as the standard claim form/attending physician statement for submission of medical claims.

The Uniform Claim Form Task Force was replaced by the National Uniform Claim Committee (NUCC) in the mid 1990s. The NUCC's goal was to develop the NUCC Data Set (NUCC-DS), a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The NUCC continues to be responsible for the maintenance of the 1500 Claim Form. Although many providers now submit electronic claims, many of their software/hardware systems depend on the existing 1500 Claim Form in its current image.

About the NUCC

The National Uniform Claim Committee (NUCC) is a voluntary organization that replaced the Uniform Claim Form Task Force in 1995. The committee was created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. It is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS) as a critical partner. The committee is a diverse group of health care industry stakeholders representing providers, payers, designated standards maintenance organizations, public health organizations, and vendors.

The NUCC was formally named in the administrative simplification section of the HIPAA of 1996 as one of the organizations to be consulted by the American National Standards Institute's accredited SDOs and the Secretary of HHS as they develop, adopt, or modify national standards for health care transactions. As such, the NUCC is intended to have an authoritative voice regarding national standard content and data definitions for non-institutional health care claims in the United States. The NUCC's recommendations in this area are explicitly designed to complement and expedite the work of the Accredited Standards Committee Electronic Data Interchange (ASC X12N) in complying with the provisions of P.L. 104-191.

The NUCC is comprised of the key parties affected by health care electronic data interchange (EDI) - those at either end of a health care transaction, generally payers and providers. Criteria for membership include a national scope and representation of a unique constituency affected by health care EDI, with an emphasis on maintaining or enhancing the provider/payer balance. Each committee member is intended to represent the perspective of the sponsoring organization and the applicable constituency. Representatives are responsible for communicating information between the committee and the group(s) they represent.

Scope of Instructions

The 1500 Claim Form instructions were initially approved by the NUCC in November 2005. The NUCC continues to research the type of data that are typically reported, as well as the required data elements that may apply to public and private payers. Therefore, the instructions have and will continue to evolve. Updated versions of this instruction manual are released each July. The ultimate goal of the NUCC is to develop standardized national instructions. The end result may require additional changes to the 1500 Claim Form in the future.

The instructions in this manual are not specific to any applicable public or private payer. Refer to specific instructions issued by your payer, clearinghouse, and/or vendor for further clarification of reporting requirements.

The 1500 Claim Form may also be used to report patient encounter data to federal, state, and/or other public health agencies. Refer to instructions issued by these agencies for further clarification of reporting requirements.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. 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. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Frequently Asked Questions

Source: www.nucc.org

Q. Why was the 1500 Claim Form changed?

A. The 1500 Claim Form was revised to accommodate reporting needs for ICD-10 and to align with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

During its work, the NUCC was made aware by the health care industry of two priorities that were included in the revisions to the 1500 Claim Form. The first was the addition of an indicator in Item Number 21 to identify the version of the diagnosis code set being report, i.e., ICD-9 or ICD-10. The need to identify which version of the code set is being reported will be important during the implementation period of ICD-10. The second priority was to expand the number of diagnosis codes that can be reported in Item Number 21, which was increased from 4 to 12. Additional revisions will improve the accuracy of the data reported, such as being able to identify the role of the provider reported in Item Number 17 and the specific dates reported in Item Number 14.

Q. What are the specific changes that were made to the 1500 Claim Form?

A. For a complete list of the changes from the current (08/05) version to the revised (02/12) version, view the Change Log document posted on the NUCC's website under the "1500 Claim Form" tab, www.nucc.org.

Q. What was the revision process that the 1500 Claim Form went through?

A. The NUCC began revising the current 1500 Claim Form in 2009. The NUCC's Data/1500 Subcommittee worked on how to best revise the current form to accommodate various needs that were identified and to better align with the Version 5010 837P electronic claim transaction. Efforts were made to keep the changes minimal to limit the amount of re-programming that would need to be done by the industry.

The NUCC's work to revise the form included two public comment periods in October 2009 and June 2011 to solicit feedback from the industry. All comments received were reviewed and carefully considered when finalizing the form. The revised version of the form was approved by the NUCC in February 2012.

Following the NUCC's approval, the form was submitted to the Centers for Medicare & Medicaid (CMS) for their approval process with the Office of Management and Budget (OMB). OMB approval of a form is required for it to be used in government programs; in this case, government health care payers.

As part of their approval process, CMS conducted a 60-day public comment period that was announced in the Federal Register in May 2012. CMS reviewed and responded to the comments they received. The form was then submitted to OMB for its approval and conducted an additional 30-day public comment period in October 2012 that was also announced in the Federal Register. The form was approved by OMB on June 11, 2013.

Q. When do I have to start using the revised 1500 Claim Form?

A. The NUCC will review its proposed implementation timeline after it has received approval from CMS. It will also seek input from its members, including Medicare, on the timing of the transition and the deadline to use only the 02/12 version 1500 Claim Form.

Q. What is the symbol at the top of the 1500 Claim Form?

A. The symbol is a Quick Response code or "QR" code. If you take a picture of it with a smartphone and the necessary app, it will take you to the NUCC website. Scanners can be programmed to read the symbol and identify that the 1500 Claim Form is the 02/12 version.

Q. Why was Patient Status in Item Number 8 eliminated?

A. The data that was reported in this field are not reported in the 837P, which is why the field was eliminated. The NUCC intends to align reporting requirements of the paper 1500 Claim Form with the electronic 837P transaction whenever possible.

Q. Why was Other Insured's Data of Birth, Sex in Item Number 9b eliminated?

A. The data that was reported in this field are not reported in the 837P, which is why the field was eliminated. The NUCC intends to align reporting requirements of the paper 1500 Claim Form with the electronic 837P transaction whenever possible.

Q. Why was Employer's Name or School in Item Number 9c eliminated?

A. The data that was reported in this field are not reported in the 837P, which is why the field was eliminated. The NUCC intends to align reporting requirements of the paper 1500 Claim Form with the electronic 837P transaction whenever possible.

Q. Why was Item Number 10d changed from Reserved for Local Use to Claim Codes? Can I still report other data in this field?

A. The NUCC has limited this field for the reporting of various claim codes, such as Condition Codes. Requests for any additional codes that the industry would like to have reported here should be brought to the NUCC. The need to report other data in this field should also be brought to the NUCC, so the Committee can determine the appropriate place to report that data. Requests for the NUCC can be submitted at: nuccinfo@nucc.org.

Q. Why was Employer's Name or School in Item Number 11b eliminated?

A. The data that was reported in this field are not reported in the 837P, which is why the field was eliminated. The NUCC intends to align reporting requirements of the paper 1500 Claim Form with the electronic 837P transaction whenever possible.

Q. Why Item Number 11b changed to Other Claim ID?

A. The NUCC received input on the need to report Property and Casualty Claim Number. It was determined that a broader need could be addressed by using the existing field and creating the ability to report a qualifier to indicate the type of number being reported. This format allows for the flexibility to add additional qualifiers and types of numbers in the future.

Q. Why was a qualifier added to Item Number 14?

A. A qualifier was added to Item Number 14 in order to specifically identify which date is being reported in the field.

Q. Why was Item Number 15 changed to Other Date?

A. The NUCC received input that the reporting of a date for Same or Similar Illness was not needed. There was interest by the industry to be able to report other dates associated with the claim. The ability to report a qualifier to indicate which date is being reported was added. This format allows for the flexibility to add additional qualifiers for other dates in the future.

Q. Why was a qualifier added to Item Number 17?

A. A qualifier was added to Item Number 17 in order to specifically identify the role of the provider being reported in the field.

Q. Why was Item Number 19 changed from Reserved for Local Use to Additional Claim Information? Can I still report other data in this field?

A. The NUCC renamed this field in an effort to limit the use of it as an open text field. Specific needs for reporting data in this field should be brought to the NUCC, so the Committee can determine the need and develop uniform instructions for the reporting of the information. Requests for the NUCC can be submitted at: nuccinfo@nucc.org.

Q. Why was a place added in Item Number 21 to report an indicator?

A. There will be a transition period during the implementation of ICD-10 and an indicator is needed to identify which codes are being reported on the claim; ICD-9 vs. ICD-10.

Q. Why were additional lines added in Item Number 21 to report more diagnosis codes?

A. The NUCC received input from the industry that the ability to report up to 12 diagnosis codes on a claim was a priority.

Q. Why were the line labels in Item Number 21 changed from numbers to letters?

A. The line labels are the diagnosis pointers that are reported in 24E. Each service line (24) can point to up to four diagnosis codes. Changing to letters was necessary because an entry of "12" in 24E could be interpreted as both "1" and "2" or "12". In addition, there was not enough space in 24E to allow the reporting of 2-digit pointers and still accommodate up to four pointers.

Q. Why was "Medicaid" removed from the title of Item Number 22?

A. "Medicaid" was removed so the field is no longer specific to Medicaid resubmissions. The field can now be used for resubmissions with any payer.

Q. Why was Balance Due in Item Number 30 eliminated?

A. The data that was reported in this field are not reported in the 837P, which is why the field was eliminated. The NUCC intends to align reporting requirements of the paper 1500 Claim Form with the electronic 837P transaction whenever possible.

Q. Now that there are open fields, can they be used to report any data, even though they are marked "Reserved for NUCC Use?"

A. No. These fields cannot be used to report additional data. If there are needs to report additional data on the 1500 Claim Form, the request should be brought to the NUCC, so the Committee can determine the need and develop uniform instructions for the reporting of the information. Requests for the NUCC can be submitted at: nuccinfo@nucc.org.

Q. Why wasn't "Pay-to Address" added to the 1500 Claim Form with the revisions?

A. The NUCC had lengthy discussions about the need to accommodate "Pay-to Address" on the 1500 Claim Form. The final conclusion was that payers will use the address they have on file for the provider to send payment. If the payer does not have the provider's address on file, they would want to contact them before sending a payment to an address submitted on the form. Therefore, the NUCC determined that it was unnecessary to accommodate "Pay-to Address" on the form.

Q. Why aren't there fields on the 1500 Claim Form to report coordination of benefits (COB) data?

A. The NUCC has analyzed the ability of the 1500 Claim Form to accommodate COB and has come to the conclusion that it cannot do this. The paper claim form simply does not have enough space to allow for the reporting of all COB data. The common method used today to submit COB claims is to attach a copy of the explanation of benefits (EOB) to the 1500 Claim Form. The decision was made to not add any COB data elements to the 1500 Claim Form since only some of the data could be accommodated and, therefore, an EOB would still need to be included.

Q. Do I have to use a form that is in red ink or can I use a form that is copied or printed in black ink?

A. In order for the form to be read by a scanner, the form must be in red ink. The red ink that is specified for the form allows scanners to drop the form template during the imaging of the paper. This "cleaner" image is easier and faster to process with data capture automation such as ICR/OCR (Intelligent Character Recognition/Optical Character Recognition) software. Your vendor may choose not to process claim forms that are submitted in black ink.

Q. My payer has given me different instructions than the manual. What should I do?

A. For The NUCC's goal in developing the 1500 Claim Form Reference Instruction Manual is to help standardize nationally the manner in which the form is completed. We do recognize, however, that some payers will give their providers different instructions on how to complete certain Item Numbers on the form. On the title page of the instruction manual, it states:

The NUCC has developed this general instructions document for completing the 1500 Health Insurance Claim Form. This document is intended to be a guide for completing the 1500 Claim Form and not definitive instructions for this purpose. Any user of this document should refer to the most current federal, state, or other payer instructions for specific requirements applicable to using the 1500 Claim Form.

Q. My organization wants to insert its own specific instructions into the NUCC Reference Instruction Manual. Can we do this?

A. No. Any payer-specific or other organization-specific modifications to instructions must be maintained in a separate document that references the NUCC Reference Instruction Manual.

Q. Where can I find a crosswalk between the 02/12 1500 Claim Form and 837P?

A. A crosswalk between the 02/12 1500 Claim Form and the 837P is available on the NUCC website, www.nucc.org.

The NUCC Data Set, which is a more comprehensive mapping between the 837P and the 1500 Claim Form, is currently being updated for the 02/12 form. The updated Data Set will be posted on the NUCC website once it is completed.

Claim Form Instructions

The following instructions for the 1500 are excerpts from NUCC and Medicare instructions, but they are generally universal. Consult with your specific insurance payer for their adaptations. However, these instructions apply to claims submitted on paper or electronically and must be used when filing claims with Medicare. Please note that payment rules can change frequently for any payer.

The instructions included in this section are compiled from the following documents along with commentary by Find-A-Code:

- 1500 Health Insurance Claim Form Reference Instruction Manual Form Version 02/12 (version 10.0 7/22), by the National Uniform Claim Committee (NUCC).
- Medicare instructions by CMS (Rev. 11037, 05-27-22) are added to the NUCC instructions in shaded areas.

Item Number and Title are in bold text.

NUCC instructions are in regular text.

NUCC descriptions are in italic text.

Medicare instructions are shaded. Note that chapter references in Medicare text refer to a chapter in the Medicare Claims Processing Manual, not a chapter of this publication.

Field specifications are omitted from this *InstaGuide.* **(See the full instructions by the NUCC.)**

Item examples are by NUCC.

> Alerts, commentary and/or examples by Find-A-Code are enclosed in a box like this

▶ ◀ Identifies new or revised official CMS or NUCC instructional text for this year.

Official Instructions

Overall Instructions

Each item number includes the title, instructions, description, field specifications, and example. The examples provided in the instructions are demonstrating how to enter the data in the field. They are not providing instruction on how to bill for certain services.

Punctuation

The use of punctuation is noted in the instructions section of each Item Number.

Multiple Page Claims

When reporting line item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim. If there are more than 50 service lines, the claim must be split.

NOTE 1: Form images throughout this manual may not be to scale.

NOTE 2: Data content entered into fields may not fill all allotted space.

Medicare Instructions

The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Providers meeting an ASCA exception may send their claims to Medicare on a paper claim form. (For more information regarding ASCA exceptions, refer to Chapter 24.)

Providers sending professional and supplier claims to Medicare on paper must use Form CMS-1500 in a valid version. This form is maintained by the National Uniform Claim Committee (NUCC), an industry organization in which CMS participates. Any new version of the form must be approved by the White House Office of Management and Budget (OMB) before it can be used for submitting Medicare claims. When the NUCC changes the form, CMS coordinates its review, any changes, and approval with the OMB.

The NUCC has recently changed the Form CMS-1500, and the revised form received OMB approval on June 10, 2013. The revised form is version 02/12, OMB control number 0938-1197.

The revised form will replace the previous version of the form 08/05, OMB control number 0938-0999.

Throughout this chapter, the terms, "Form CMS-1500," "Form 1500," and "CMS-1500 claim form" may be used to describe this form depending upon the context and version. The term, "CMS-1500 claim form" refers to the form generically, independent of a given version.

Medicare will conduct a dual-use period during which providers can send Medicare claims on either the old or the revised forms. When the dual-use period is over, Medicare will accept paper claims on only the revised Form 1500, version 02/12.

For the implementation and dual-use dates, contractors shall consult the appropriate implementation change requests for the revised Form 1500. Providers and other interested parties may obtain the implementation dates on the CMS web site @ www.cms.gov.

Reminder: Regardless of the paper claim form version in effect: **Providers cannot submit ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10.**

Medicare A/B MACS (B), DME MACS, physicians, and suppliers are responsible for purchasing their own CMS-1500 claim forms. Forms can be obtained from printers or printed in-house as long as they follow the specifications developed by the NUCC. Photocopies of the CMS-1500 claim form are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the CMS-1500 claim form for processing. To purchase forms from the U.S. Government Printing Office, call (202) 512-1800.

The following instructions are required for a Medicare claim. They apply to both the 08/05 and 02/12 versions of the form except where noted. A/B MACs (B) and DME MACs should provide information on completing the CMS-1500 claim form to all physicians and suppliers in their area at least once a year.

These instructions represent the minimum requirements for using this form to submit a Medicare claim. However, depending on a given Medicare policy, there may be other data that should also be included on the CMS-1500 claim form; if so, these additional requirements are addressed in the instructions you received for such policies (e.g., other chapters of this manual).

Providers may use these instructions to complete this form. The CMS-1500 claim form has space for physicians and suppliers to provide information on other health insurance. This information can be used by A/B MACs (B) to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is another insurer to which Medicare can forward billing and payment data following adjudication if the provider is a physician or supplier that participates in Medicare. (See Pub. 100-05. Medicare Secondary Payer Manual, Chapter 3, and Chapter 28 of this manual).

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for <u>all</u> these fields. For instance, a provider of service or supplier will <u>not</u> be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Legend	Description
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 1998 = 98)
CCYY	4 position Year (e.g., 1998 = 1998)
(MM | DD | YY) or (MM | DD | CCYY)	A space must be reported between month, day, and year (e.g., 12 | 15 | 98 or 12 | 15 | 1998). This space is delineated by a dotted vertical line on the Form CMS-1500)
(MMDDYY) or (MMDDCCYY)	No space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

Field Specific Instructions

Carrier Block

Description: The payer is the carrier, health plan, third-party administrator, or other payer that will handle the claim. This information directs the claim to the appropriate payer.

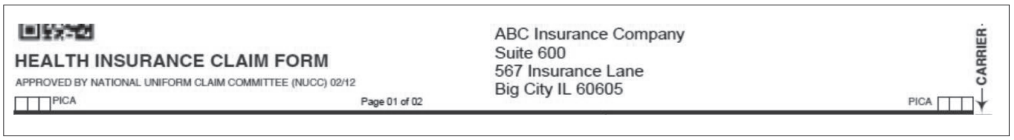
The carrier block is located in the upper center and right margin of the form. In order to distinguish this version of the form from previous versions, the Quick Response (QR) code symbol and the date approved by the NUCC have been added to the top, left-hand margin.

NUCC Instructions

Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format:

- 1st Line – Name
- 2nd Line – First line of address
- 3rd Line – Second line of address, if necessary
- 4th Line – City, State (2 characters) and ZIP Code

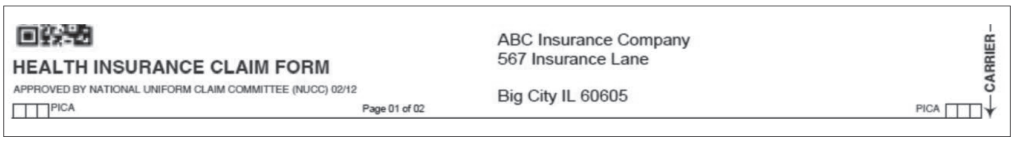
Example:
Four line address:



Line	Descriptor
• 4	Payer Name
• 5	Payer Address 1
• 6	Payer Address 2
• 7	Payer City State and ZIP

Example:

Three line address:



1st Line – Name
2nd Line – Line of address
3rd Line – Leave blank
4th Line – City State (2 characters) and ZIP code

Line	Descriptor
4	Payer Name
5	Payer Address 1
6	Leave blank
7	Payer City State and ZIP

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

When printing page numbers on multiple page claims (generally done by clearinghouses when converting 5010A1 to the 1500 Claim Form), print the page numbers in the Carrier Block on Line 8 beginning at column 32. Page numbers are to be printed as:

Page XX of YY

Alert

- Each line of the carrier block can have up to 40 characters per line.
- If you are submitting electronic claims, many clearinghouses have a Carrier ID number they want you to include as part of the Payer Name. Please check with your clearinghouse to see how they want the Carrier ID formatted.
- Field specifications and field details are not generally included in this publication.
- Instead of using "Page XX of YY" for multiple pages, one way to avoid confusion is to simply split the claim. Only bill related charges on one claim and put additional days of service on a separate claim..

Alert

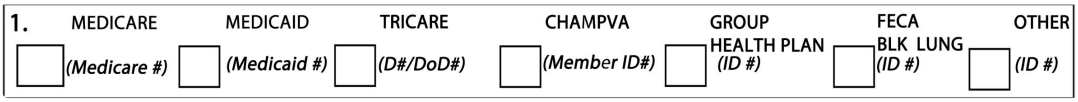
On the claim form, PICA boxes are located on the top right and the top left. They are usually (also historically) used for printer alignment and not used by most payers. Pica is actually a font size which most likely led to its name.

However, some payers are now requesting that a letter or other information be entered in these boxes. Follow the instructions from the payer on how to use these boxes. They will tell you which letter to use and which box on the claim form (PICA Left side box 1, 2, or 3 or PICA Right side box 1, 2, or 3) to place it in.

Items 1-13: Patient and Insured Information

Note: If the patient can be identified by a unique Member Identification Number, the patient is considered to be the "insured." The patient is reported as the insured in the insured data fields and not in the patient fields.

Item Number 1, Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other



Description: "Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other" means the insurance type to which 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.

NUCC Instructions

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 Instructions

Shows the type of health insurance coverage applicable to this claim by the appropriately checked box; check the Medicare box.

Item Number 1a, Insured's ID Number

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X0123456789

Description: The "Insured's ID Number" is the identification number of the insured. This information identifies the insured to the payer.

NUCC Instructions

Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field.

For TRICARE: Enter the DoD Benefits Number (DBN 11-digit number) from the back of the ID card.

For Workers Compensation Claims: Enter the appropriate identifier of the employee.

For Other Property and Casualty Claims: Enter the appropriate identifier of the insured person or entity.

Medicare Instructions

Enter the patient's Medicare beneficiary identifier whether Medicare is the primary or secondary payer. This is a required field.

Item Number 2, Patient's Name

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe Jr, John, J

Description: The "Patient's Name" is the name of the person who received the treatment or supplies.

NUCC Instructions

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.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

If the patient's name is the same as the insured's name (i.e., the patient is the insured), then it is not necessary to report the patient's name.

> Alert: Listing the first name first will likely cause claims processing to be delayed. Be sure to check spelling. A transposition of letters can result in delay or denial.

Medicare Instructions

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

Item Number 3, Patient's Birth Date, Sex

3. PATIENT'S BIRTH DATE MM DD YY SEX
01 01 1987 M [X] F [ ]

Description: The "Patient's Birth Date, Sex" is information that will identify the patient and it distinguishes persons with similar names.

NUCC Instructions

Enter the patient's 8-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave blank.

Medicare Instructions

Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item Number 4, Insured's Name

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John, J

Description: The "Insured's Name" identifies the person who holds the policy, which would be the employee for employer-provided health insurance.

NUCC Instructions

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.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

For Workers Compensation Claims: Enter the name of the Employer.

For Other Property & Casualty Claims: Enter the name of the insured person or entity

> Alert: When the insured and the patient are the same person, it is acceptable to enter "SAME" in this field.

Medicare Instructions

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

Item Number 5, Patient's Address (multiple fields)

5. PATIENT'S ADDRESS (No., Street)	
123 Main Street 101	
CITY	STATE
Anytown	IL
ZIP CODE	TELEPHONE (Include Area Code)
60610	(312) 5551212

Description: The "Patient's Address is the patient's permanent residence. A temporary address or school address should not be used.

NUCC Instructions

Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

If the patient's address is the same as the insured's address, then it is not necessary to report the patient's address.

"Patient's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extentions are not supported.

For Workers' Compensation and Other Property and Casualty Claims: If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

> Alert: Verify this demographic information. The patient's address is not always the same as the insured's address. Using the incorrect address is a common cause of delayed payment.

Medicare Instructions

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 phone number.

Item Number 6, Patient Relationship to Insured

6. PATIENT RELATIONSHIP TO INSURED							
Self	☐	Spouse	☐	Child	X	Other	☐

Description: The "Patient Relationship to Insured" indicates how the patient is related to the insured. "Self" would indicate that the insured is the patient. "Spouse" would indicate that the patient is the husband or wife or qualified partner, as defined by the insured's plan. "Child" would indicate that the patient is the minor dependent, as defined by the insured's plan. "Other" would indicate that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured's plan.

NUCC Instructions

Enter an X in the correct box to indicate the patient's relationship to insured when Item Number 4 is completed. Only one box can be marked.

If the patient is a dependent, but has a unique Member Identification Number and the payer requires the identification number be reported on the claim, then report "Self", since the patient is reported as the insured.

Medicare Instructions

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

Item Number 7, Insured's Address (multiple fields)

7. INSURED'S ADDRESS (No., Street)	
123 Main Street	
CITY	STATE
Anytown	IL
ZIP CODE	TELEPHONE (Include Area Code)
60610	(312)5551212

Description: The "Insured's Address" is the insured's permanent residence, which may be different from the patient's address in Item Number 5.

NUCC Instructions

Enter the insured's address. 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.

Do not use punctuation (i.e., commas, periods) or other symbols, in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

"Insured's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extentions are not supported.

For Workers Compensation Claims: Enter the address of the Employer.

For Other Property and Casualty Claims: Enter the address of the insured noted in Item Number 4.

For Workers' Compensation and Other Property and Casualty Claims: If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

> Alert: Enter the word "SAME" when the address is the same as the patient's.

Medicare Instructions

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

Item Number 8, Reserved for NUCC Use

8. RESERVED FOR NUCC

Description: This field is reserved for NUCC use.

NUCC Instructions

This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

Medicare Instructions

Form version 08/05: Check the appropriate box for the patient's marital status and whether employed or a student.

Form version 02/12: Leave blank.

Item Number 9, Other Insured's Name

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, Mary, A

Description: The "Other Insured's Name" indicates that there is a holder of another policy that may cover the patient.

NUCC Instructions

If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. 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.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Find-A-Code: Some payers may want the name entered without commas. Be aware of individual payer differences.

Find-A-Code: For Medicare, Item Number 9 should only be completed when the provider is a participating physician or supplier, and when the patient wishes to assign his/her benefits under a Medigap policy to the participating physician or supplier. Participating providers 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 provider is called a mandated Medigap transfer.

Other supplemental coverage should not be listed in Item Number 9 or 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.

Find-A-Code: This is an important item to properly complete because incorrectly billing Medicare as primary when it should have been secondary is high on the Office of the Inspector General's (OIGs) list of red flags.

Medicare Instructions

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. (See chapter 28.)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the 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 A/B MAC (B) or DME MAC to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item Number 9a, Other Insured's Policy or Group Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER
X9876543210

Description: The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9.

NUCC Instructions

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.

Alert: If you enter a policy and/or group number in Item 9a, then Item 9d must also be completed.

Medicare Instructions

Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a.

Item Number 9b, Reserved for NUCC Use

8. RESERVED FOR NUCC

Description: This field is reserved for NUCC use.

NUCC Instructions

This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

Medicare Instructions

Form version 08/05: Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Form version 02/12: Leave blank.

Item Number 9c, Reserved for NUCC Use

c. EMPLOYER'S NAME OR SCHOOL NAME
Community Hospital

Description: This field is reserved for NUCC use.

NUCC Instructions

This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

Medicare Instructions

Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card.

For example:

1257 Anywhere Street
Baltimore, MD 21204

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

Item Number 9d, Insurance Plan Name or Program Name

d. INSURANCE PLAN NAME OR PROGRAM NAME
XYZ Insurance Company

Description: The "Insurance Plan Name or Program Name" identifies the name of the plan or program of the other insured as indicated in Item Number 9.

NUCC Instructions

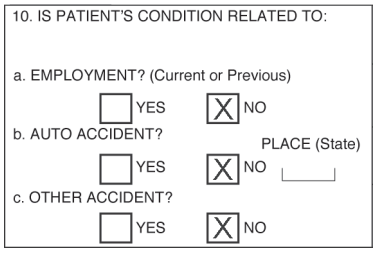
Enter the other insured's insurance plan or program name.

Alert: If you enter a policy and/or group number in Item 9a, then Item 9d must also be completed.

Medicare Instructions

Enter the Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID). Refer to chapter 28, section 70.6.4, of this manual for more information.

Items Number 10a–10c, Is Patient's Condition Related To:



Description: 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.

NUCC Instructions

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.

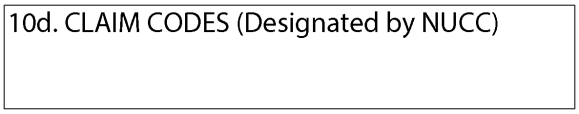
The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.

> Alert: Any item marked "yes" indicates there may be other insurance.
>
> Alert: The OIG is carefully evaluating claims they paid which may have been the liability of another party – secondary vs primary.

Medicare Instructions

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

Item Number 10d, Claim Codes (Designated by NUCC)



Description: The "Claim Codes" identify additional information about the patient's condition or the claim.

NUCC Instructions

When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.

When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at www.nucc.org under Code Sets.

When reporting more than one code, enter three blank spaces and then the next code.

For Workers Compensation Claims: Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). Note: Do not use Condition Codes when submitting a revised or corrected bill.

Medicare Instructions

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

Item Number 11, Insured's Policy, Group, or FECA Number

11. INSURED'S POLICY GROUP OR FECA NUMBER
A1234

Description: The "Insured's Policy, Group, or FECA Number" is the alphanumeric identifier for the health, auto, or other insurance plan coverage. The FECA number is the 9 character alphanumeric identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101.

NUCC Instructions

Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed.

Do not use a hyphen or space as a separator within the policy or group number.

Medicare Instructions

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 Block 11, 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

> **Tip:** Call the Medicare Coordination of Benefits Contractor at 1-800-999-1118 and ask them who the primary payer is.

NOTE: For a paper claim to be considered for MSP benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.)

Item Number 11a, Insured's Date of Birth, Sex

a. INSURED'S DATE OF BIRTH MM DD YY 01 01 1958 SEX M [X] F [ ]

Description: The "Insured's Date of Birth, Sex" is the birth date and gender of the insured as indicated in Item Number 1a.

NUCC Instructions

Enter the 8-digit date of birth (MM | DD | YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

Medicare Instructions

Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item Number 11b, Other Claim ID (Designated by NUCC)

b. OTHER CLAIM ID (Designated by NUCC)
Y4 | 112233445566

Description: The "Other Claim ID" is another identifier applicable to the claim.

NUCC Instructions

Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.

When submitting to Property and Casualty payers, e.g. Automobile, Homeowner's, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:

Y4 Agency Claim Number (Property Casualty Claim Number)

Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.

For Workers Compensation or Property & Casualty: Required if known. Enter the claim number assigned by the payer.

Medicare Instructions

Form version 08/05: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

Form version 02/12: provide this information to the right of the vertical dotted line.

Item Number 11c, Insurance Plan Name or Program Name

c. INSURANCE PLAN NAME OR PROGRAM NAME
ABC Insurance Company

Description: The "Insurance Plan Name or Program Name" is the name of the plan or program of the insured as indicated in Item Number 1a.

NUCC Instructions

Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.

Alert: If there is a change in the insured's insurance status, e.g., retired, enter either a six-or eight digit retirement date preceded by the word "Retired."

Medicare Instructions

Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the complete primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item Number 11d, Is there another Health Benefit Plan?

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[X] YES [ ] NO ***If yes***, return to and complete item 9 a-d.

Description: "Is there another health benefit plan?" indicates that the patient has insurance coverage other than the plan indicated in Item Number 1.

Tip: Any item marked "yes" indicates there may be other insurance.

Alert: The OIG is carefully evaluating claims they paid which may have been the liability of another party – secondary vs primary.

NUCC Instructions

When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9a, and 9d. Only one box can be marked.

Medicare Instructions

Leave blank. Not required by Medicare.

Item Number 12, Patient's or Authorized Person's Signature

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 SOF DATE

Description: The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

NUCC Instructions

Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY). If there is no signature on file, leave blank or enter "No Signature on File."

Alert: The signed agreement(s) should be kept with the patient's records in the provider's files. The authorization may be on a lifetime basis. It need not be a specific period of time and the patient can cancel it at any time. This agreement is effective with the date of the signing, and is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

During an audit, the payer may request that you provide them with a Signature on File or patient signature

Medicare Instructions

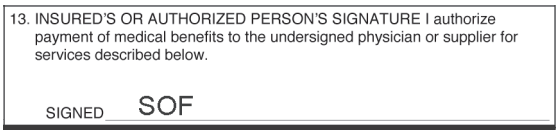
The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." 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, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

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

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

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

Item Number 13, Insured's or Authorized Person's Signature



Description: The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits.

NUCC Instructions

Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."

Medicare Instructions

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. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

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 CMS has 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 affect supplemental payments to providers and/or their patients.

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

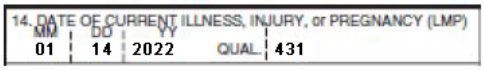
NOTE: This can be "Signature on File" signature and/or a computer generated signature.

Items 14–33: Physician or Supplier Information

Medicare Instructions

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item Number 14, Date of Current Illness, Injury, or Pregnancy (LMP)



Description: The "Date of Current Illness, Injury, or Pregnancy" identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy.

NUCC Instructions

Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) 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.

Enter the applicable qualifier to identify which date is being reported.

431 Onset of Current Symptoms or Illness
484 Last Menstrual Period

Enter the qualifier to the right of the vertical, dotted line.

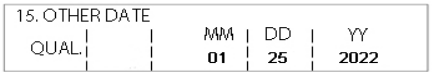
> Alert: When there is a new course of treatment (e.g., exacerbations), this field may be used to indicate the new start date of the updated treatment plan.

Medicare Instructions

Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Additional information for form version 02/12: Although this version of the form includes space for a qualifier, Medicare does not use this information; do not enter a qualifier in item 14.

Item Number 15, Other Date



Description: The "Other Date" identifies additional date information about the patient's condition or treatment.

NUCC Instructions

Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.

Enter the applicable qualifier to identify which date is being reported.

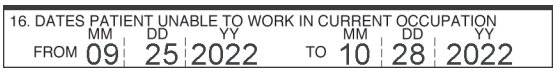
454 Initial Treatment
304 Latest Visit or Consultation
453 Acute Manifestation of a Chronic Condition
439 Accident
455 Last X-ray
471 Prescription
090 Report Start (Assumed Care Date)
091 Report End (Relinquished Care Date)
444 First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

Medicare Instructions

Leave blank.

Item Number 16, Dates Patient Unable to Work in Current Occupation



Description: "Dates Patient Unable To Work in Current Occupation" is the time span the patient is or was unable to work.

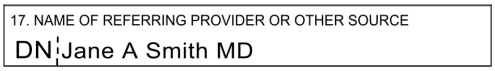
NUCC Instructions

If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Medicare Instructions

If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item Number 17, Name of Referring Provider or Other Source



Description: The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported.

NUCC Instructions

Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

> Tip: If the name is very long, use the complete last name and as much of the first name as will fit in the remaining space.

Medicare Instructions

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17. When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

Additional instructions for form version 02/12: Enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the dotted vertical line on item 17.

NOTE: Under certain circumstances, Medicare permits a non-physician practitioner to perform these roles. Refer to Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Enter non-physician practitioner information according to the rules above for physicians.

The term "physician" when used within the meaning of §1861(r) of 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.

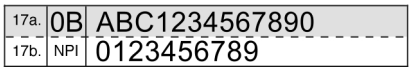
Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 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 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. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;
- Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

Item Number 17a and 17b (Split Field)



Item 17a, Other ID#

Description: The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional.

NUCC Instructions

The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only.)

Alert:

- Other ID: Often providers ask which other ID number they should be using for a specific payer (e.g., State Farm, Cigna). Different payers have different requirements. Obtain this information directly from the payer.
- Taxonomy codes are specific classifications for providers and are a component of NPI applications. The National Uniform Claim Committee (NUCC) is presently maintaining the Health Care Provider Taxonomy list. See www.wpc-edi.com/codes for the taxonomy codes.

Medicare Instructions

Leave blank.

Item Number 17b, NPI#

Description: The NPI number refers to the HIPAA National Provider Identifier number.

NUCC Instructions

Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

Medicare Instructions

Enter the NPI of the referring, ordering, or supervising physician or non-physician practitioner listed in item 17. All physicians and non-physician practitioners who order services or refer Medicare beneficiaries must report this data.

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

Item Number 18, Hospitalization Dates Related to Current Services

Description: The "Hospitalization Dates Related to Current Services" refers to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

NUCC Instructions

Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Medicare Instructions

Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item Number 19, Additional Claim Information (Designated by NUCC)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Description: "Additional Claim Information" identifies additional information about the patient's condition or the claim.

NUCC Instructions

Please refer to the most current instructions from the applicable public or private payer regarding the use of this field. Report the appropriate qualifier, when available, for the information being entered. Do not enter a space, hyphen, or other separator between the qualifier and the information.

For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier "NTE", followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words.

ADD Additional Information
CER Certification Narrative
DCP Goals, Rehabilitation Potential, or Discharge Plans
DGN Diagnosis Description
TPO Third Party Organization Notes

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
NTEADDSurgery was unusually long due to scarring

For additional identifiers (REFs), the following are the qualifiers in 5010A1. Enter the qualifier "REF", followed by the qualifier, then the identifier. Do not enter spaces between the qualifier and identifier.

0B State License Number
1G Provider UPIN Number
G2 Provider Commercial Number
LU Location Number (This qualifier is used for Supervising Provider only
N5 Provider Plan Network Identification Number
SY Social Security Number (The social security number may not be used for Medicare.)
X5 State Industrial Accident Provider Number
ZZ Provider Taxonomomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

Taxonomy codes or other identifiers reported in this field must not be reportable in other fields, i.e., Item Numbers 17, 24J, 32, or 33.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
REFG21234567890

Alert: When reporting a second item of data, enter three blank spaces then the next qualifier number/code/information.

For Supplemental Claim Information (PWK), the following are the qualifiers in the 5010A1. Enter the qualifier "PWK", followed by the appropriate Report Type Code, the appropriate Transmission Type Code, then the Attachment Control Number. Do not enter spaces between the qualifiers and data.

REPORT TYPE CODE

03	Report Justifying Treatment Beyond Utilization
04	Drugs Administered
05	Treatment Diagnosis
06	Initial Assessment
07	Functional Goals
08	Plan of Treatment
09	Progress Report
10	Continued Treatment
11	Chemical Analysis
13	Certified Test Report
15	Justification for Admission
21	Recovery Plan
A3	Allergies/Sensitivities Document
A4	Autopsy Report
AM	Ambulance Certification
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
BR	Benchmark Testing Results
BS	Baseline
BT	Blanket Test Results
CB	Chiropractic Justification
CK	Consent Form(s)
CT	Certification
D2	Drug Profile Document
DA	Dental Models
DB	Durable Medical Equipment Prescription
DG	Diagnostic Report
DJ	Discharge Monitoring Report
DS	Discharge Summary
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
HC	Health Certificate
HR	Health Clinic Records
I5	Immunization Records
IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document OE Objective Physical Examination (including vital signs) Document
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

TRANSMISSION TYPE CODE

AA	Available on Request at Provider Site
BM	By Mail

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
PWK03AA12363545465

When reporting multiple separate items, enter three blank spaces and then the next qualifier and followed by the information.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
NTEADD Surgery was unusually long due to scarring PWKOBBM1213141

Alert: This "additional claim information" box can be very useful. This is the one place on the 1500 Claim Form where explanatory information can be given. The new NUCC guidelines provide additional information on how to appropriately use qualifiers to help ensure proper claim adjudication. If there is not enough space, check with the payer to determine their requirements. Some may allow using "REF" with the appropriate "Report Type Code" along with the attached report. Providers typically use this box to provide clarifying information (such as rationale for modifiers to procedure codes in Item Number 21).

Note that supplemental information relating to a specific procedure code should use the shaded area of Item Number 21 instead of this field.

Medicare Instructions

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

NOTE: Effective May 23, 2008, all provider identifiers submitted on the CMS-1500 claim form MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) 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 Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for A/B MAC (B) review.

Instructions for Not Otherwise Classified (NOC) Codes – Any unlisted services or procedure code. **Note:** When reporting NOC codes, this field must be populated as specified below.

Enter the drug's name and dosage when submitting a claim for NOC drugs.

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

When billing for unlisted laboratory tests using a NOC code, this field **MUST** include the specific name of the laboratory test(s) and/or a short descriptor of the test(s). Claims for unlisted laboratory tests that are received without this information shall be treated according to the requirements found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, Section 80.3.2 and "returned as unprocessable." Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) requires reporting entities to report private payor payment rates for laboratory tests and the corresponding volumes of tests. In compliance with PAMA, CMS must collect private payor data on unique tests currently being paid as a NOC code, Not Otherwise Specified (NOS) code, or unlisted service or procedure code.

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 obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," 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 non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

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 HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) 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 demonstration ID number "56" for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, Chapter 1, Section 30.2.9 for additional information.)

Note: Effective May 23, 2008, all provider identifiers submitted on the CMS-1500 claim form MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill A/B MACs (B) for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item Number 20, Outside Lab? $ Charges

20. OUTSIDE LAB?	$ CHARGES
[X] YES [ ] NO	112500

Description: "Outside Lab? $ Charges" indicates that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs.

NUCC Instructions

Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim.

If "Yes" is marked, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.

When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

Tip: Most payers DO NOT want the charges included in the total. It is better to bill lab charges with the appropriate CPT/HCPCS code on Item 24.

Medicare Instructions

Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition 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 anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form CMS-1500. Multiple anti-markup 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. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to the anti-markup payment limitation.

Item Number 21, Diagnosis or Nature of Illness or Injury

ICD-9 Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind. 9
A. 99859	B. 7806	C. V180	D. E8788
E.	F.	G.	H.
I.	J.	K.	L.

ICD-10 Example

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind. 0
A. O139	B. O6012x0	C. J0190	D.
E.	F.	G.	H.
I.	J.	K.	L.

Description: The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

NUCC Instructions

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9 ICD-9-CM

0 ICD-10-CM

Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.

Enter the codes left justified on each line to identify the patient's diagnosis or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.

Tip: Up to 12 diagnosis codes can be accepted by Medicare and most payers. Remember that the primary diagnosis code submitted on a claim should be the main reason for the patient encounter AND that all services rendered must have adequate supporting diagnoses. Remember to record any non-billed diagnostic codes in the the patient's chart.

Tip: The following are common diagnosis coding problems that could possibly cause delay or denial of payments:

- Not coding to the highest level of specificity
- The code does not establish medical necessity
- Using a chronic diagnosis as the primary diagnosis when it is not the reason for the encounter
- Using an ICD-10-CM manifestation code alone or as the primary diagnosis, when coding guidelines instruct you to list an etiology code first.
- Using an external cause code alone or as the primary diagnosis

Medicare Instructions

Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use diagnosis codes to the highest level of specificity for the date of service. Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Reminder: Do not report ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10-CM, on either the old or revised version of the CMS-1500 claim form.

For form version 08/05, report a valid ICD-9-CM code. Enter up to four diagnosis codes.

For form version 02/12, it may be appropriate to report either ICD-9-CM or ICD-10-CM codes depending upon the dates of service (i.e., according to the effective dates of the given code set).

- The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

  Enter the indicator as a single digit between the vertical, dotted lines.

- Do not report both ICD-9-CM and ICD-10-CM codes on the same claim form. If there are services you wish to report that occurred on dates when ICD-9-CM codes were in effect, and others that occurred on dates when ICD-10-CM codes were in effect, then send separate claims such that you report only ICD-9-CM or only ICD-10-CM codes on the claim. (See special considerations for spans of dates below.)
- If you are submitting a claim with a span of dates for a service, use the "from" date to determine which ICD code set to use.
- Enter up to 12 diagnosis codes. Note that this information appears opposite lines with letters A-L. Relate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
- Do not insert a period in the ICD-9-CM or ICD-10-CM code.

Item Number 22, Resubmission and/or Original Reference Number

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7	ABC1234567890

Description: "Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

NUCC Instructions

List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field.

When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

7 Replacement of prior claim
8 Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

Medicare Instructions

Leave blank. Not required by Medicare.

Item Number 23, Prior Authorization Number

23. PRIOR AUTHORIZATION NUMBER
1234567890A

Description: The "Prior Authorization Number" is the payer assigned number authorizing the service(s).

NUCC Instructions

Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

Do not enter hyphens or spaces within the number.

Alert: This item can only contain one authorization code for one condition. Any additional conditions and authorization should be reported on a separate 1500 form.

Medicare Instructions

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 an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the NPI of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

For ambulance claims, enter the ZIP code of the loaded ambulance trip's point-of-pickup.

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

Item Number 24

	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	

NUCC Instructions

Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. Providers must verify requirements for this supplemental information with the payer.

Medicare Instructions

The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

Item Number 24A, Date(s) of Service [lines 1–6]

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY
09	30	05	09	30	22

Description: "Date(s) of Service" indicates 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.

NUCC Instructions

Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, 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.

When required by payers to provide additional narrative description of an unspecified code, NDC, contract rate, or tooth numbers and areas of the oral cavity enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/ information. The information may extend to 24G. Further instructions on entering supplemental information with qualifiers, including examples, are on page 45.

Note: The NUCC instructions regarding page 45 are found in the segment titled "Instructions and Examples of Supplemental Information Item Number 14" beginning on page 43.

Medicare Instructions

Enter a 6-digit or 8-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. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item Number 24B, Place of Service [lines 1–6]

Description: The "Place of Service" Code identifies the location where the service was rendered.

NUCC Instructions

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: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Alert

- For Medicare claims (and many other payers), the "From" and "To" dates cannot be greater than one month.
- When reporting a place of service other than the primary POS, Item Number 32 is also required. A separate claim could be submitted for each place of service (POS) as appropriate. When reporting a place of service other than the primary POS, Item Number 32 is also required. A separate claim could be submitted for each place of service (POS) as appropriate.

Note: Current Place of Service Codes and definitions by CMS are included at the end of this *InstaGuide.*

Medicare Instructions

Enter the appropriate place of service code(s) from the list provided in Section 10.5. Identify the setting, 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 patient who is a registered inpatient or an outpatient (off campus or on campus) of a hospital, use the inpatient hospital POS code 21, off Campus-Outpatient Hospital POS code 19, or On Campus-Outpatient Hospital POS code 22, respectively, as discussed in section 10.5 of this chapter.

Item Number 24C, EMG [lines 1–6]

Description: "EMG" identifies if the service was an emergency.

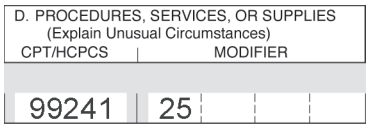
NUCC Instructions

Check with payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in 5010A1.

Medicare Instructions

Medicare providers are not required to complete this item.

Item Number 24D, Procedures, Services, or Supplies [lines 1–6]



Description: "Procedures, Services or Supplies" identify the medical services and procedures provided to the patient.

NUCC Instructions

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 2-character modifiers. The specific procedure code(s) must be shown without a narrative description.

Medicare Instructions

Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The CMS-1500 claim form has the capacity to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (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.

Return as unprocessable if an "unlisted procedure code" or a NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item Number 24E, Diagnosis Pointer [lines 1–6]

Description: The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.

NUCC Instructions

In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM or ICD-9-CM diagnosis codes must be entered in Item Number 21. Do not enter them in 24E.

Enter letters left justified in the field. Do not use commas between the letters.

Alert:

- Even though 12 diagnosis codes are allowed in Item Number 21, only 4 diagnosis pointers may be entered in Item Number 24E.
- It should be noted that in addition to avoiding the use of commas between letters, the use of spaces or dashes should also be avoided.

Medicare Instructions

This is a required field.

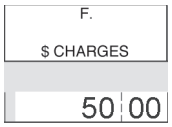
Enter the diagnosis code reference number or letter (as appropriate, per form version) as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number/letter per line item. When multiple services are performed, enter the primary reference number/letter for each service.

When using form version 08/05, this reference will be either a 1, or a 2, or a 3, or a 4.

When using form version 02/12, the reference to supply in 24E will be a letter from A-L. Otherwise, the instructions above apply.

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

Item Number 24F, $ Charges [lines 1–6]



Description: "$ Charges" is the total billed amount for each service line.

NUCC Instructions

Enter the charge amount for each listed service.

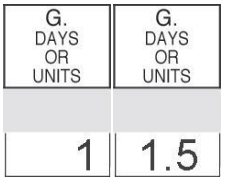
Enter the number right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area of the field if the amount is a whole number.

> Alert: Some payers accept decimals in this field and some do not. Verify with the payer to determine their preferred method.

Medicare Instructions

Enter the charge for each listed service.

Item Number 24G, Days or Units [lines 1–6]



Description: "Days or Units" is the number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS coding manual(s).

NUCC Instructions

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.

Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management").

Medicare Instructions

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 130.6 of this manual.

Beginning with dates of service on and after January 1, 2011, for ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a "0" before the decimal (e.g. 0.9). See Pub. 100-04, chapter 15, §20.2 for more information on loaded mileage and §30.1.2 for more information on reporting fractional mileage.

NOTE: This field should contain an appropriate numerical value. The A/B MAC (B) should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, contractors shall automatically default "0.1" unit when total mileage units are missing in this field.

Item Number 24H, EPSDT/Family Plan [lines 1–6]

EPSDT:

Family Planning — Yes:

Family Planning — No:

EPSDT and Family Planning:

Description: The "EPSDT/Family Plan" identifies certain services that may be covered under some state plans.

NUCC Instructions

For reporting of Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning services, refer to specific payer instructions.

EPSDT

When EPSDT services are reported on this claim, identify the status of the referral by entering one of the following reason codes right justified in the shaded area of the field.

The following codes for EPSDT are used in 5010A1:

- AV Available – Not Used (Patient refused referral.)
- S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)
- ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)
- NU Not Used (Used when no EPSDT patient referral was given.)

Family Planning

When there is a requirement to report this is a Family Planning service, enter Y for "YES" in the unshaded area of the field.

When there is no requirement to report this is a Family Planning service, leave the field blank.

Medicare Instructions

Leave blank. Not required by Medicare.

Item Number 24I, ID Qualifier [lines 1–6]

Description: 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.

NUCC Instructions

Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

The NUCC defines the following qualifiers used in 5010A1:

- 0B State License Number
- 1G Provider UPIN Number
- G2 Provider Commercial Number
- LU Location Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

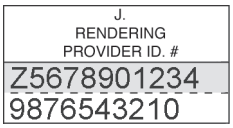
The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Medicare Instructions

Leave blank. Not required by Medicare

Item Number 24J, Rendering Provider ID # [lines 1–6]



Description: The individual performing/rendering the service should be reported in 24J and the qualifier indicating if the number is a non-NPI is reported in 24I. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.

NUCC Instructions

The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Enter numbers left justified in the field.

Medicare Instructions

Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Device Identifier of the Unique Device Identifier for supplies
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ Narrative description of unspecified code
N4 National Drug Codes (NDC)
DI Device Identifier of the Unique Device Identifier (UDI)
CTR Contract rate
JP Universal/National Tooth Designation System
JO ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

Examples: 1000.00
123.45

Additional Information for Reporting NDC

When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Examples: 1234.56
2
99999999.999

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

F2	International Unit	ME	Milligram	UN	Unit
GR	Gram	ML	Milliliter		

When reporting compound drugs, a statement of ingredients may be required to be attached to the claim.

When required to report both the repackaged NDC and original NDC of a drug, use the shaded area of 24. Report the information in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code.

UDI Replacement of NDC for Supplies

National Health Related Items Code (NHRIC) and National Drug Code (NDC) numbers assigned to some supplies/devices are being replaced with a Unique Device Identifier (UDI). When required to report a supply and that supply's NHRIC/NDC has been replaced by a UDI, report the Device Identifier (DI) portion of the UDI.

Medical and Surgical Supplies

The following qualifiers are to be used when regulations mandate the use of the Universal Product Number (UPN) for reporting medical and surgical supplies:

EN EAN/UCC - 13
EO EAN/UCC - 8
HI HIBC (Health Care Industry Bar Code)

Supplier Labeling Standard Primary Data Message

UK GTIM 14 - digit data structure
UP UCC - 12

Additional Information for Reporting Tooth Numbers and Areas of the Oral Cavity

When reporting tooth numbers, add in the following order: qualifier, tooth number, e.g., JP16. When reporting an area of the oral cavity, enter in the following order: qualifier, area of oral cavity code, e.g., JO10.

When reporting multiple tooth numbers for one procedure, add in the following order: qualifier, tooth number, blank space, tooth number, blank space, tooth number, etc., e.g., JP1 16 17 32.

When reporting multiple tooth numbers for one procedure, the number of units reported in 24G is the number of teeth involved in the procedure.

When reporting multiple areas of the oral cavity for one procedure, add in the following order: qualifier, oral cavity code, blank space, oral cavity code, etc., e.g., JO10 20.

When reporting multiple areas of the oral cavity for one procedure, the number of units reported in 24G is the number of areas of the oral cavity involved in the procedure.

The following are the codes for tooth numbers, reported with the JP qualifier:

1 – 32	Permanent dentition
51 – 82	Permanent supernumerary dentition
A – T	Primary dentition
AS – TS	Primary supernumerary dentition

The following are the codes for areas of the oral cavity, reported with the JO qualifier:

00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

For further information on these codes, refer to the Current Dental Terminology (CDT) Manual available from the American Dental Association.

EXAMPLES

Please note: The following examples are of how to enter different types of supplemental information in 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services.

Unspecified Code:

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. #
ZZKaye Walker														G2	12345678901
10	01	05	10	01	05	12		E1399		12	165 00	1	N	NPI	01234546789

NDC Code:

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. #
N45914801665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	01234546789

Repackaged NDC

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. #
N455289047590 UN30 ORIGN400025152531													N	G2	12345678901
10	01	05	10	01	05	11		J3490		A	500	00 30	N	NPI	0123456789

UDI Replacement

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. #
DI12345678912345678912345678912345678 9													N	G2	12345678901
10	01	05	10	01	05	11		E0110		A	200	00 1	N	NPI	0123456789

Tooth 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. #
JP1													N	1B	12345678901
10	01	05	10	01	05	11		D7240		1	500 00	1	N	NPI	01234546789

Multiple Tooth Numbers

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. #
JP1 16 17 32													N	G2	12345678901
10	01	05	10	01	05	11		D7240		1	500 00	4	N	NPI	01234546789

Area of Oral Cavity

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. #
JO10													N	G2	12345678901
10	01	05	10	01	05	11		41820		1	500 00	1	N	NPI	01234546789

Multiple Areas of Oral Cavity

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. #
JO10 20													N	G2	12345678901
10	01	05	10	01	05	11		D7310		1	500 00	2	N	NPI	01234546789

Item Number 25, Federal Tax ID Number

25. FEDERAL TAX I.D. NUMBER	SSN	EIN
		X

Description: The "Federal Tax ID Number" is the unique identifier assigned by a federal or state agency.

NUCC Instructions

Enter the "Federal Tax ID Number" (employer ID number or SSN) 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.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

Medicare Instructions

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

Item Number 26, Patient's Account No.

26. PATIENT'S ACCOUNT NO.
12341234

Description: The "Patient's Account No." is the identifier assigned by the provider.

NUCC Instructions

Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

NOTE: While the patient's account number is a required data element in the 837P claim transaction, it is strongly encouraged but not required on a paper claim. Payers or their vendors may choose to enter a default into the field if no number is reported by the provider for reporting in the 835 remittance. If no default number is used within the internal processing system, payers would report a single zero on an 835 remittance per the 835 TR3.

Alert: This is your internal patient account number. Use it only if it helps your office to run more smoothly. It is not generally required by payers.

Medicare Instructions

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

Item Number 27, Accept Assignment?

Description: The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

NUCC Instructions

Enter an X in the correct box. Only one box can be marked.

Report "Accept Assignment?" for all payers.

Alert: Only when assignment is **authorized** by the patient in Item Number 13 can it be **accepted** (or rejected) by the provider in Item Number 27.

Tip: Non-Medicare claims: By choosing to accept assignment, you know that the payment should come directly to your office without going through the patient. The provider may then bill the patient for the allowable "Patient Portion."

Medicare Instructions

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 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.

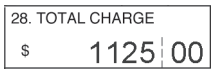
Tip: These are mandatory Medicare assignment situations. When billing any of the above services/supplies, the "Yes" box should be checked.

Alert: Medicare Participating providers have signed an agreement with the Medicare program to accept assignment of Medicare Part B payment for all covered services provided to Medicare patients. Non-participating providers may accept or decline assignment of Medicare benefits on a claim-by-claim basis. However, they cannot accept assignment in Item Number 27 if it is not authorized in Item Number 13.

Note: It is very important to complete this field in accordance with Medicare requirements. Participating providers should always check 'yes.' Non-participating providers have the option to check 'yes' or 'no' unless the supply/service is a mandatory assignment situation. If the provider makes no entry in Item Number 27, the carrier will automatically assume the following:

- Participating providers will be a "yes."
- Non-participating providers will be a "no."
- Mandatory assignment situations (above) will be a "yes" (e.g., labs, physician assistants, etc.).

Item Number 28, Total Charge



Description: The "Total Charge" is the total billed amount for all services entered in 24F (lines 1–6).

NUCC Instructions

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

Enter the amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Medicare Instructions

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

Item Number 29, Amount Paid

Description: The "Amount Paid" is the payment received from the patient or other payers.

NUCC Instructions

Enter total amount the patient and/or other payers paid on the covered services only.

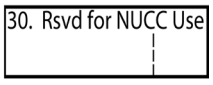
Enter the amount right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area if the amount is a whole number.

Alert: Do not enter a previously paid amount that is unrelated to the claim.

Medicare Instructions

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

Item Number 30, Reserved for NUCC Use



Description: This field is reserved for NUCC use.

NUCC Instructions

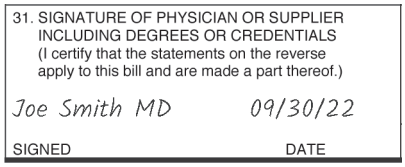
This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

Medicare Instructions

Leave blank. Not required by Medicare.

Item Number 31, Signature of Physician or Supplier Including Degrees or Credentials



Description: The "Signature of the Physician or Supplier Including Degrees or Credentials" refers to the authorized or accountable person and the degree, credentials, or title.

NUCC Instructions

"Signature of Physician or Supplier Including Degrees or Credentials" does not exist in 5010A1.

Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

> Alert: An actual signature is not required by most payers. Some actually prefer to have a printed signature and date.

Medicare Instructions

Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

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

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

Item Number 32, 32a, and 32b

Item Number 32, Service Facility Location Information

Description: The name and address of facility where services were rendered identifies the site where service(s) were provided.

NUCC Instructions

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.

If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.

Enter the name and address information in the following format:

1st Line – Name
2nd Line – Address
3rd Line – City, State and ZIP code

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

Medicare Instructions

For services payable under the physician fee schedule and anesthesia services, enter the name and 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, enter 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, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate CMS-1500 claim form shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

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 Form CMS-1490S, 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 chapter 1 for disposition of the claim. The A/B MAC (B) 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 and address 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 claim form shall 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 the supplier is a certified mammography screening center, enter the 6-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.

Item Number 32a: NPI#

Description: The NPI number refers to the HIPAA National Provider Identifier number.

NUCC Instructions

Enter the NPI number of the service facility location in 32a.

Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

Medicare Instructions

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

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier on the claim on reference laboratory claims, even if the performing physician or supplier is enrolled in a different A/B MAC (B) jurisdiction. See Pub. 100-04, Chapter 1, §10.1.1 for more information regarding claims filing jurisdiction.

Item Number 32b: Other ID#

Description: The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

NUCC Instructions

Enter the 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 NUCC defines the following qualifiers used in 5010A1:

- 0B State License Number
- G2 Provider Commercial Number
- LU Location Number

Medicare Instructions

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

Item Number 33, 33a, and 33b

33. BILLING PROVIDER INFO & PH # (312)5552222	
Physician Practice Inc 1234 Healthcare Street 101 Anytown IL 606101234	
a. 9876543210	b. 1BZ5678901234

Item Number 33, Billing Provider Info & Ph

Description: The billing provider's or supplier's billing name, address, ZIP code, and phone number is the billing office location and telephone number of the provider or supplier.

NUCC Instructions

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

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen. Do not use a hyphen or space as a separator within the telephone number.

If reporting a foreign address, contact payer for specific reporting instructions.

5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.

Medicare Instructions

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

Item Number 33a: NPI#

Description: The NPI number refers to the HIPAA National Provider Identifier number.

NUCC Instructions

Enter the NPI number of the billing provider in 33a.

Medicare Instructions

Enter the NPI of the billing provider or group. This is a required field.

Item Number 33b, Other ID#

Description: The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional.

NUCC Instructions

Enter the 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 NUCC defines the following qualifiers used in 5010A1:

- 0B State License Number
- G2 Provider Commercial Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping,classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

Medicare Instructions

Item 33b is not generally reported. However, for some Medicare policies you may be instructed to use this item; direction as to how to use this item will be in the instructions you received regarding the specific policy, if applicable.

Appendix A: Definitions

The following definitions apply to terms used on the 1500 Claim Form.

PROVIDER TERMS

Referring Provider

The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported.

Examples include, but are not limited to, primary care provider referring to a specialist; orthodontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency.

Ordering Provider

The Ordering Provider is the individual who requested the services or items being reported on this service line.

Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.

Rendering Provider

5010A1 837P

The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.

Future Versions of 837P

The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, that individual is considered the Rendering Provider.

The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.

Supervising Provider

The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported.

An example includes, but is not limited to, supervision of a resident physician.

Purchased Service Provider

A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who is billing for the service.

Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider.

INDIVIDUAL TERMS

Patient

An individual who has received, is receiving, or intends to receive health care services. (Health care services as defined by federal and state regulations.)

Dependent

An individual who has insurance coverage under the policy of another individual.

Subscriber

An individual or entity that is the holder of an insurance policy (including health, property and casualty, auto, workers' compensation, or other liability) for the purposes of health care services.

Insured

An individual or entity that has insurance coverage.

Appendix B: Abbreviations

AMA	American Medical Association
BLK Lung	Black Lung
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services, formerly HCFA
COB	Coordination of Benefits
CPT®	Current Procedural Terminology, 4th Edition
DD	Day, indicates entry of two digits for the day
DME	Durable Medical Equipment
EIN	Employer Identification Number
EMG	Emergency
EPSDT	Early & Periodic Screening, Diagnosis, and Treatment
F	Female
FECA	Federal Employees' Compensation Act
GTIN	Global Trade Item Number
HCFA	Health Care Financing Administration, currently CMS
HCPCS	HCFA Common Procedural Coding System
HIBCC	Health Industry Business Communications Council
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
ICD-9-CM	International Classification of Disease - Revision 9 - Clinical Modification
ICD-10-CM	Internal Classification of Disease, Revision 10, Clinical Modification
I.D. or ID.	Identification
ID # or ID. #	Identification Number
INFO	Information
LMP	Last Menstrual Period
M	Male
MM	Month, indicates entry of two digits for the month
NDC	National Drug Codes
No.	Number
NUCC	National Uniform Claim Committee
NUCC-DS	National Uniform Claim Committee Data Set
NPI	National Provider Identifier

OMB	Office of Management and Budget
OZ	Product number Health Care Uniform Code Council
PH #	Phone Number
QUAL.	Qualifier
REF.	Reference
SOF	Signature on File
SSN	Social Security Number
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
USIN	Unique Supplier Identification Number
VP	Vendor Product Number
YY	Year, indicates entry of two digits for the year
YYYY	Year, indicates entry of four digits for the year (YYYY)

Place of Service Codes for Professional Claims

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies and clarifications regarding these codes. Effective dates are in parentheses for each POS Code.

01 Pharmacy

A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (10/1/2005)

02 Telehealth ▸Provided Other than in Patient's Home

The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (See "Special Considerations" below.) (1/1/2017)◂

03 School

A facility whose primary purpose is education. (1/1/2003)

04 Homeless Shelter

A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (See "Special Considerations" below) (1/1/2003)

05 Indian Health Service Free-standing Facility

A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (See "Special Considerations" below) (1/1/2003)

06 Indian Health Service Provider-based Facility

A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (See "Special Considerations" below) (1/1/2003)

07 Tribal 638 Free-Standing Facility

A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization. (See "Special Considerations" below) (1/1/2003)

08 Tribal 638 Provider-Based Facility

A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See "Special Considerations" below.) (1/1/2003)

09 Prison/Correctional Facility

A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (See "Special Considerations" below.) (7/1/2006)

10 ▸Telehealth Provided in Patient's Home

The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (See "Special Considerations" below.) (01/01/2022)◂

11 Office

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

13 Assisted Living Facility

Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (10/1/2003)

14 Group Home

A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). (Code effective, 10/1/ 2003; description revised, effective 04/1/2004)

15 Mobile Unit

A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

(See "Special Considerations" below) (1/1/2003)

16 Temporary Lodging

A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (4/1/2008)

17 Walk-in Retail Health Clinic

A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (See "Special Considerations" below) (No later than May 1, 2010)

18 Place of Employment/Worksite

A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (No later than May 1, 2013)

19 Off Campus-Outpatient Hospital

A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick and injured persons who do not require hospitalization or institutionalization. (See "Special Considerations " below.) (1/1/2016)

20 Urgent Care Facility

Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (1/1/2003)

21 Inpatient Hospital

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 On Campus-Outpatient Hospital

A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (See "Special Considerations " below.) (Description revised 1/1/16)

23 Emergency Room-Hospital

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center

A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center NF

A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.

26 Military Treatment Facility

A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27-30 Unassigned

31 Skilled Nursing Facility

A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.

33 Custodial Care Facility

A facility which provides room, board and other personal assistance services, generally on a long term basis, and which does not include a medical component.

34 Hospice

A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 Unassigned

41 Ambulance—Land

A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 Ambulance—Air or Water

An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43-48 Unassigned

49 Independent Clinic

A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (10/1/2003)

50 Federally Qualified Health Center

A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility-Partial Hospitalization

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center

A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54 Intermediate Care Facility/Individuals with Intellectual Disabilities

A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57 Non-residential Substance Abuse Treatment Facility

A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (10/1/2003)

58-59 Unassigned

60 Mass Immunization Center

A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61 Comprehensive Inpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63-64 Unassigned

65 End-Stage Renal Disease Treatment Facility

A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

66-70 Unassigned

71 State or Local Public Health Clinic

A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic

A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

73-80 Unassigned

81 Independent Laboratory

A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

82-98 Unassigned

99 Other Place of Service

Other place of service not identified above.

Special Considerations

▸Special Considerations for Telehealth Claims (Codes 02, 10)

Note that while the modification of POS Code 02 and the creation of POS Code 10 are effective in the National POS code set effective January 1, 2022, Medicare contractors received instructions regarding how to process claims with these codes starting April 4, 2022, so that Medicare would align with existing Telehealth claims processing policy, as well as be considered HIPAA compliant. ◂

Special Considerations for Homeless Shelter (Code 04)

Note that for the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home. Because DME is payable in the beneficiary's home, the crosswalk for Homeless Shelter (code 04) to Office (code 11) that was mandated effective January 1, 2003, may need to be adjusted or local policy developed so that HCPCS codes for DME are covered when other conditions are met and the beneficiary is in a homeless shelter. If desired, local contractors are permitted to work with their medical directors to determine a new crosswalk such as from Homeless Shelter (code 04) to Home (code 12) or Custodial Care Facility (code 33) for DME provided in a homeless shelter setting. If a local contractor is currently paying claims correctly, however, it is not necessary to change the current crosswalk.

Special Considerations for Indian Health Service (Codes 05, 06) and Tribal 638 Settings (Codes 07, 08)

Medicare does not currently use the POS codes designated for these settings. Follow the instructions you have received regarding how to process claims for services rendered in IHS and Tribal 638 settings. If you receive claims with these codes, you must initially accept them in terms of HIPAA compliance. However, follow your "return as unprocessable" procedures after this initial compliance check. Follow your "return as unprocessable" procedures when you receive paper claims with these codes. (Note that while these codes became part of the National POS code set effective January 1, 2003, Medicare contractors received instructions regarding how to process claims with these codes effective October 1, 2003, so that Medicare could be HIPAA compliant by October 16, 2003).

Special Considerations for Mobile Unit Settings (Code 15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a skilled nursing facility. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15. Apply the nonfacility rate to payments for services designated as being furnished in POS code 15; apply the appropriate facility or nonfacility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health professional shortage area as defined under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in section 1886(d)(2)(D) of the Act, the originating physician's office should use POS code 11 (Office) in order to ensure appropriate payment for services on the list of Medicare Telehealth Services.

Special Considerations for Prison/Correctional Facility Settings (Code 09)

The addition of code 09 to the POS code set and Medicare claims processing reflects Medicare's compliance with HIPAA laws and regulations. Local contractors must continue to comply with CMS current policy that does not allow payment for Medicare services in a penal institution in most cases. The addition of a POS code for a prison/correctional facility setting does not supersede this policy. (See Pub. 100-04, Medicare Claims Processing, section 10.4, chapter 1.)

Special Considerations for Walk-In Retail Health Clinic (Code 17) (Effective no later than May 1, 2010)

It should be noted that, while some entities in the industry may elect to use POS code 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in chapter 18, section 10 of this manual. Contractors are to instruct providers and suppliers of immunizations to continue to follow these Medicare billing rules. However, Medicare contractors are to accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

Special Considerations for Services Furnished to Registered Inpatients

When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

Special Considerations for Outpatient Hospital Departments

The place of service (POS) code for "Outpatient Hospital" has been expanded. The description of POS 22 has been revised from "Outpatient Hospital" to "On Campus-Outpatient Hospital" and POS 19 has been created for the "Off CampusOutpatient Hospital" setting. Throughout this Internet Only Manual (IOM) you may find references to "Outpatient Hospital" that do not differentiate between the "On Campus" or "Off Campus" setting; however, any reference to POS 22 (formerly "Outpatient Hospital") found anywhere within the IOM is now defined as "On Campus-Outpatient Hospital." In addition, POS 19 will also apply in the majority of situations describing an outpatient hospital setting.

When a physician/practitioner furnishes services to an outpatient of a hospital, payment is made under the PFS at the facility rate. Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital shall, at a minimum, report the outpatient hospital POS code 22 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the outpatient hospital POS code 22 is a minimum requirement for purposes of triggering the facility payment amount under the PFS when services are provided to a registered outpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered hospital outpatient, the appropriate outpatient facility POS code may be reported consistent with the code list annotated in this section (instead of POS 22). For example, physicians/practitioners may use POS code 23 for services furnished to a patient registered in the emergency room, POS 24 for patients registered in an ambulatory surgical center, and POS 56 for patients registered in a psychiatric residential treatment center.

NOTE: Physicians/practitioners who perform services in a hospital outpatient department shall use, at a minimum, POS code 19 (Off CampusOutpatient Hospital) or POS code 22 (On Campus-Outpatient Hospital).

Code 19 or 22 (or other appropriate outpatient department POS code as described above) shall be used unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65.

Physicians shall use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital. Use of POS code 11(office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

Special Consideration for Ambulatory Surgical Centers (Code 24)

When a physician/practitioner furnishes services to a patient in a Medicareparticipating ambulatory surgical center (ASC), the POS code 24 (ASC) shall be used.

NOTE: Physicians/practitioners who perform services in an ASC shall use POS code 24 (ASC). Physicians/practitioners are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC, which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the

"distinct entity" criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time -- and the physician service was actually performed in the office suite portion of the facility.

See Pub 100-07, Medicare State Operations Manual, Appendix L - Guidance for Surveyors: Ambulatory Surgical Centers for a complete set of applicable ASC definitions, basic requirements, and conditions of coverage. It is available at the following link: http://www.cms.gov/manuals/Downloads/som107ap_l_ambulatory.pdf

Special Considerations for Hospice (Code 34)

When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a beneficiary is in an "inpatient" respite or general "inpatient" care stay, the POS code 34 (hospice) shall be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (Hospice) shall be used to designate the POS on the claim.

For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner's office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient's physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, shall assign the POS code that represents that setting, as appropriate.

There may be use of nursing homes as the hospice patient's "home," where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating "houses" or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and nonphysician practitioners, including the patient's independent attending physician or nurse practitioner, shall use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

Special Considerations for Non-residential Opioid Treatment Facility (Code 58)

NOTE: OUD treatment services furnished at Opioid Treatment Programs are not considered physician services and are separeately paid under the bundled payment established under section 1833(a)(1)(CC) and 1834(w) of the Social Security Act.

Paper Claims

Adjudicate paper claims with codes from the National POS code set as you would for electronic claims.

Index

Notes: