

CMS 1500 Instructions

Disclaimer

This information release is the property of Noridian Administrative Services, LLC (NAS). It may be freely distributed in its entirety but may not be modified, sold for profit or used in commercial documents.

The information is provided “as is” without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All models, methodologies and guidelines are undergoing continuous improvement and modification by NAS and the Centers for Medicare & Medicaid Services (CMS). The most current edition of the information contained in this release can be found on the NAS web site at www.noridianmedicare.com and the CMS web site at www.cms.hhs.gov.

The identification of an organization or product in this information does not imply any form of endorsement.

Updated 04/01/08

*The Internet Only Manual (IOM) Pub 100-04, Medicare Claims Processing Manual, Chapter 26 was used to create this tutorial. **The following instructions apply to the CMS-1500 Claim Form (08-05).** For complete information on CMS-1500 Claim Form (08-05), refer to www.cms.hhs.gov/manuals/downloads/clm104c26.pdf.*

The *CMS-1500 Form* (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The *CMS-1500 Form* is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc. To purchase them from the U.S. Government Printing Office, call (202) 512-1800.

The *CMS-1500 Form* answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. The following instructions are required for a Medicare claim. Throughout this document the following formats will be used to report dates:

Legend	Description
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 2006 = 06)
CCYY	4 position Year (e.g., 2006 = 2006)

(MM | DD | YY) or
(MM | DD | CCYY)

A space must be reported between month, day, and year (e.g., 12 | 15 | 06 or 12 | 15 | 2006). This space is delineated by the dotted vertical line on the *CMS-1500 Form*)

(MMDDYY) or
(MMDDCCYY)

No space must be reported between month, day, and year (e.g., 121506 or 12152006). The date must be recorded as one continuous number.

Reminder: Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24A. *The format chosen must be consistent throughout these items. Intermixing the two formats on the claim is not allowed.* For instance, a provider of service or supplier will **not** be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19, and a 6-digit date for item 24A. Items 12 and 31 are exempt from this requirement.

NOTE: *Throughout these instructions, you will notice that some items are **bolded** and some are in italics. Noridian Administrative Services (NAS) has used boldface type to emphasize certain points and provided additional clarification on items through the use of italics.*

Item	Instructions
Item 1	<p><i>Type of Health Insurance Coverage Applicable to the Claim</i> Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.</p> <p><i>Insured's ID Number</i> (Patient's Medicare Health Insurance Claim Number - HICN) This is a required field. Enter the patient's Medicare HICN whether Medicare is the primary or the secondary payer. <i>Be sure to include the suffix and do not use spaces and/or dashes. (Example of proper HICN submission: 123456789A) An invalid HICN will cause a claim to deny or be rejected as unprocessable.</i></p>
Item 1a	<p><i>If a patient's HICN begins with an alpha character, their claims must be filed to Railroad Medicare. The address is indicated here.</i> <i>Palmetto Government Benefits Administration</i> <i>PO BOX 10066</i> <i>Augusta GA 30999</i></p>
Item 2	<p>NOTE: <i>Noridian Administrative Services (NAS) is prohibited from forwarding such claims.</i></p> <p><i>Patient's Name</i> This is a required field. Enter the patient's last name, first name, and middle initial, if any, as it appears on the patient's Medicare card (e.g., Jones John J). <i>Include only one space between the last name, first name, and middle initial. If the name is not an identical match, the claim will be rejected as</i></p>

unprocessable.

Do not submit extra spaces, nicknames, or descriptions such as Jr., Sr., deceased, or the estate of (unless indicated on the Medicare card). Do not extend the beneficiary's name beyond the confines of this box.

Patient's Birth Date and Sex

Item 3 Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex. *Only one box should be indicated; either M or F. Marking both or neither will cause the claim to be rejected as unprocessable.*

Insured's Name

Item 4 **If Medicare is primary, leave blank.** 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.

Patient's Address and Telephone Number

Item 5 **This is a required field and must be filled in completely.** Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and telephone number.

Patient's Relationship to Insured

Item 6 **If Medicare is primary, leave blank.** Check the appropriate box for the patient's relationship to *the* insured when item 4 is completed.

Insurance Primary to Medicare, Insured's Address and Telephone Number

Item 7 **Complete this item only when items 4, 6, and 11 are completed.** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME.

Patient's Marital Status and Whether Employed or a Student

Item 8 Check the appropriate box for the patient's marital status and whether employed or a student.

Medigap Benefits, Other Insured's Name

If no Medigap benefits are assigned, leave blank. 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. This field may be used in the future for supplemental insurance plans.

Item 9 **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 of

the Medicare Claims Processing Manual.)

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 carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Medigap Benefits, Other Insured’s Policy or Group Number

Item 9a **If no Medigap benefits are assigned, leave blank.** Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP. *Do not enter other types of insurance (e.g., supplemental).*

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

Item 9b ***Medigap Benefits, Other Insured’s Date of Birth***

Enter the Medigap insured’s 8-digit birth date (MM | DD | CCYY) and sex.

Medigap Benefits, Employer’s/School Name

Item 9c **If a Medigap PayerID is entered in item 9d, leave blank.** 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

Medigap Benefits, Insurance Plan/Program Name, PAYERID Number

Item 9d **Enter the nine-digit PAYERID number of the Medigap insurer.** If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

NOTE: *The configuration of the PAYERID is alpha numeric and up to 9 digits. NAS assigns five digit alpha numeric or numeric PAYERID numbers rather than nine digit numbers.*

Condition Relationship? Employment, Auto Liability, or Other Accident

Items 10a–10c Check “YES” or “NO” by placing an (X) in the center of the box 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 10d *Leave blank. Not required by NAS.*

Insured’s Policy Group or FECA Number

Note: *All claims can be submitted electronically. For more information please refer to the EDISS web site.*

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 *for the service date(s)*, enter the insured’s policy or group number *within the confines of the box* and proceed to items 11a-11c. Items 4, 6, and 7 must also be completed. ***If item 11 is left blank, the claim will be denied as unprocessable.***

Item 11

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, *do not enter “n/a,” “not,” etc.*, enter the word NONE *within the confines of the box* 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 MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word NONE in *item 11 of the CMS-1500 Form*, when

submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare- Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
 - Working Aged (*Type 12*);
 - Disability (Large Group Health Plan – *Type 43*); and
 - End Stage Renal Disease (*ESRD – Type 13*);
- No Fault (*Type 14*) and/or Other Liability (*Type 47*); and
- Work-Related Illness/Injury:
 - Workers' Compensation (*Type 15*);
 - Black Lung (*Type 41*); and
 - Veterans Benefits (*Type 42*).

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, a policy or group number must be entered in this item. In addition, 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.) *Without an attached EOB from the primary insurance, the claim will be denied.*

Insured's Date of Birth and Sex

Item 11a **This item must be completed if a policy or group number is reported in item 11 AND is different from the date in item 3.** Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Insurance Primary to Medicare, Employer's Name

Item 11b **This item must be completed if a policy or group number is submitted in item 11.** Enter the 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. *Please add the employer's address and telephone number to the attached copy of the EOB.*

Insurance Plan/Program Name

Item 11c **This item must be completed if a policy or group number is submitted in item 11.** Enter the nine-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. *Please include the telephone number of the primary payer.* This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d **Leave blank. Not required by Medicare.**

Patient's or Authorized Person's Signature

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 alphanumeric date (e.g., January 1, 2008) 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, "General Billing Requirements" may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless *the* patient or the patient's representative revokes this arrangement.

Item 12

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.

Medigap Benefits, Insured's/Authorized Person's Signature

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.

Item 13

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

Date of Current Illness/Injury/Pregnancy

- For **current illness, injury, or pregnancy**, enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date.
- 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 of *x-ray (if used to demonstrate subluxation)* in item 19.

Item 14

Item 15 Leave blank. Not required by Medicare.

Item 16 ***Dates Patient Unable to Work in Current Occupation***

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 *the* patient is unable to work.

An entry in this field may indicate employment related insurance coverage.

Name of the Referring or Ordering Physician

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. *Use the physician's last name and as much of the first name as will fit in item 17. Do not use "self," "friend," etc.*

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.

Item 17

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 Section 1833(q) of the *Social Security Act*. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that result from 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.

Do not extend the name beyond the confines of this box. Only enter what will fit into item 17. Do not run the name into item 17a or 17b.

UPIN of the Referring/Ordering Physician

Enter the ID Qualifier 1G in the smaller box and the CMS assigned UPIN of the referring/ordering physician listed in item 17 in the larger box. The 1G and UPIN must be submitted within the confines of the appropriate boxes. The UPIN may be reported on the CMS-1500 Form until May 22, 2008, and MUST be reported if an NPI is not available. An invalid UPIN format will cause the claim to be rejected as unprocessable.

Item 17a

NOTE: The UPIN Registry will be discontinued May 23, 2008.

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

When a claim involves multiple referring and/or ordering physicians, a separate *CMS-1500 Form* shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2008. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.

NPI of the Referring/Ordering Physician

Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. *The NPI must be entered within the confines of the larger box. An invalid NPI will cause the claim to be rejected as unprocessable.*

Item 17b **NOTE:** Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2008, and later, 17a is not to be reported but 17b **MUST** be reported when a service was ordered or referred by a physician.

Effective May 23, 2008

Only an NPI may be entered in any provider identifier fields on claims submitted on or after May 23, 2008. Claims will be rejected when submitted with a Medicare legacy number (PIN/PTAN) or a UPIN in any provider identifying field on or after May 23, 2008.

Service Furnished as a Result of, or Subsequent to, a Related Hospitalization

Item 18 Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Narrative Field

This is a required field for the purposes outlined below.

- Item 19**
- **Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date the patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.**
 - For physical therapy, occupational therapy, and speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are **not** required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the

claim. **However**, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see item 17 and 17a *and/or* 17b, and for the identification of the supervisor, see item 24J of this section.

- 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 Benefits Policy Manual, Chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.
- Enter the drug's name, *strength*, and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.
- Enter a concise description of an “unlisted procedure code” or a “*not otherwise classified*” (NOC) code within the confines of this box. An attachment *may also need to be submitted to help expedite claim processing. If more than one unlisted procedure code is reported on the claim, precede each description in item 19 with the line item number that corresponds to the line that contains the NOC code. This will enable claims processing staff to determine the correct description for each unlisted procedure code. If billing the same unlisted procedure code more than once on the claim, you may need to indicate the charges of the procedure codes to indicate which description belongs to each line.*
- 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. ***Modifier 99 is only appropriate when more than four modifiers are necessary per claim line. When four or less modifiers apply, each modifier can be entered in the existing space in item 24D on the CMS-1500 Form.***
- Enter the statement “Homebound” when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, “Laboratory Services from Independent Labs, Physicians, and Providers,” 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 provider/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 postoperative care.**
- Enter demonstration ID number “30” for all national emphysema treatment trial claims.
- Enter the PIN (or NPI when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, Chapter 1, Section 30.2.9.1 for additional information.)
- 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).
- *If a provider is enrolled in the Competitive Acquisition Program (CAP) for Medicare Part B Drugs and Biologicals, the prescription order number (RX order #) must be reported in item 19 on the CMS-1500 Form.*
- *For ambulance suppliers, the originating site information will be entered in item 32. It is recommended that providers list both the origin and destination information in item 32. If both the origin and destination do not fit within the confines of item 32, bill the origin in item 32 and the destination information in item 19. List the name of the facility, city, state, and ZIP code. The street address is not required. When transport is beyond the “closest facility”, providers are to briefly identify why within the confines of item 19.*
- *You may place up to eight diagnosis codes on the claim form. The diagnosis that is pointed to in Item 24E must be placed in one of the first four diagnoses entry spaces in Item 21. Any indicator other than a 1, 2, 3, or 4 in Item 24E will cause the claim to deny as unprocessable. Place additional diagnosis codes 5-8 (if necessary) in Item 19. Enter only the number (with decimal if needed) and separate each diagnosis in Item 19 with a comma. [For example: 719.41, 719.42, 816.00]*

*The diagnosis codes listed in Item 19 **should not** be for codes that are **required** for payment, submit a second claim form with the **additional***

required codes in Item 21. [For example: if CPT code “A” requires three diagnosis codes for payment and CPT “B” requires three different codes for payment, these two procedures would need to be billed on two separate claim forms so the processing system could pick up all six of the diagnosis codes as payable.]

Diagnostic and Purchased Tests

This is a required field when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the “yes” block is checked.

Item 20

- A “yes” check indicates that an entity other than the entity billing for the service performed the diagnostic test.
- A “no” check indicates “no purchased tests are included on the claim.”

When “yes” is annotated, item 32 *must* be completed. **When billing for multiple purchased diagnostic tests, each test *must* be submitted on a separate CMS-1500 Form.**

Patient’s Diagnosis/Condition

Enter the patient’s diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) *must* use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for non-physician specialties shall be submitted on an attachment.

NOTE: Although ambulance suppliers are not required to submit ICD-9 codes on the claim, NAS highly encourages them to do so with the code that best describes the sign, symptom, and/or condition of the beneficiary at the time of transport.

Item 21

Enter the diagnosis code only, not the description. Any extraneous data in this field will cause an up front rejection of your claim. Do not use decimal points.

NOTE: You may place up to eight diagnosis codes on the claim form. The diagnosis that is pointed to in Item 24E must be placed in one of the first four diagnoses entry spaces in Item 21. Any indicator other than a 1, 2, 3, or 4 in Item 24E will cause the claim to deny as unprocessable. Place additional diagnosis codes 5-8 (if necessary) in Item 19. Enter only the number (with decimal if needed) and separate each diagnosis in Item 19 with a comma. [For example: 719.41, 719.42, 816.00]

*The diagnosis codes listed in Item 19 **should not** be for codes that are **required** for payment, submit a second claim form with the **additional required codes** in Item 21.* [For example: if CPT code “A” requires three diagnosis codes for payment and CPT “B” requires three different codes for payment, these two procedures would need to be billed on two separate claim

forms so the processing system could pick up all six of the diagnosis codes as payable.]

Item 22 Leave blank. Not required by Medicare

Prior Authorization Number

This is a required field for the purposes outlined below.

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

Item 23

- ***Enter the ZIP code for the point of pickup for ambulance claims.*** *Because the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup are located in the same ZIP code. However, suppliers must prepare a separate claim form for each trip if the points of pickup are located in different ZIP codes. A claim without a ZIP code or with multiple ZIP codes will be denied as unprocessable.*

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

Service Line

The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the 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. **At this time, the shaded area in 24A through 24H is not used by Medicare.** Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

Item 24

Date of Service

This is a required field. Enter a 6-digit (*MMDDYY*) or 8-digit (*MMDDCCYY*) date for each procedure, service, or supply *within the confines of this box*. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column G. Return as

Item 24A unprocessable if a date of service extends more than 1 day and a valid “to” date is not present.

When billing a date span, it must be for consecutive days. If it is not, then bill each service separately. Days billed should correspond with the number of units in column G. If days span over a month, bill the services for each month

on separate lines. Do not use quotation marks to indicate the date of service is the same as the line above. A date must be reported in this item.

Place of Service

This is a required field. Enter the appropriate 2-digit place of service code(s) from the list provided in Section 10.5 of the *Medicare Claims Processing Manual, Chapter 26*. Identify the location, using a place of service code, for each item used or service performed.

Item 24B

NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.

Enter only one place of service code per CMS-1500 Form, unless the second place of service code is 12 (patient’s home).

Item 24C Leave blank. Not required by Medicare.

Procedures, Services, or Supplies Code

This is a required field. 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 Form* has the ability 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 *must* be submitted with the claim.

Item 24D

Return as unprocessable if an “unlisted procedure code” or a “not otherwise classified” (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment.

*Modifiers must be two alpha/numeric characters. Do not place extra narrative after, under, or above the procedure code. Pricing modifiers should be placed in the first modifier position. Procedure codes should not be placed in the first modifier position. Be sure to distinguish between zeros and the letter “O”. Hyphens or any other separators should not be used between procedure codes and modifiers. **Only uppercase characters should be used for procedure codes and modifiers.***

Diagnosis Code Reference Number

This is a required field. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. **Enter only one reference number per line item.** When multiple services are performed, enter the primary reference number for each service, **either a 1, or a 2, or a 3, or a 4.** *Entering anything other than a 1, or a 2, or a 3, or a 4 will cause the claim to be rejected as unprocessable,*

Item 24E

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.

Place only a single diagnosis pointer on each line. Do not enter the ICD-9 code(s) and/or diagnosis narratives in this item. The NAS processing system is capable of referencing all diagnosis codes in item 21 as needed.

Enter the charge for each listed service

Enter the charge for each listed service. *Include the cents with dollar amounts. For example, \$24.00 must be entered as 2400 rather than 24 or 24-. Do not use dollar signs, decimals, dashes, commas, or lines. Negative dollar amounts are not allowed.*

Item 24F

NOTE: *Competitive Acquisition Program (CAP) physicians should enter a billed amount for each CAP drug. Do not enter a zero dollar amount.*

Days or Units

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 (e.g., 2 hours and 10 minutes would be reported as 130. One hour and 10 minutes would be reported as 70).

Item 24G

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of the *Medicate Claims Processing Manual*.

*Do not place zeros before or after the number of units (e.g., a service of 1 should **not** be billed as 010; it should be billed as 1. Indicate only whole numbers, e.g., do **not** bill 1.5).*

NOTE: This field should contain at least 1 day or unit. The carrier should program their system to automatically default “1” unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H **Leave blank. Not required by Medicare.** *Entering information in this item may cause delays in claims processing.*

ID Qualifier

Item 24I Enter the ID qualifier **1C** in the shaded portion *when submitting the rendering physician’s PIN in 24J. Not required by Medicare as of May 23, 2008.*

PIN/NPI of the Rendering Provider

Prior to May 23, 2008, enter the rendering provider's PIN in the shaded 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 PIN of the supervisor in the shaded portion. *Do not enter PIN numbers with the alpha state code indicator, before the PIN number. The addition of this indicator will cause the claim to be rejected as unprocessable. For example, a North Dakota PIN would be entered as 000, not N000.*

Effective May 23, 2008 and later, do not use the shaded portion. Beginning no earlier than January 1, 2007, enter the rendering provider's NPI number in the lower *non-shaded* 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 *non-shaded* portion. *An invalid NPI will cause the claim to be rejected as unprocessable.*

Information must be submitted within the confines of this box. Do not enter provider names or state postal codes in this item.

Effective May 23, 2008

Item 24J

Only an NPI may be entered in any provider identifier fields on claims submitted on or after May 23, 2008. Claims will be rejected when submitted with a Medicare legacy number (PIN/PTAN) or a UPIN in any provider identifying field on or after May 23, 2008.

Type 1 is an individual NPI. Type 2 is an organizational NPI.

Incorporated Individual with individual legacy number and individual NPI:

24J – Enter nothing

33a – Enter type 1 Individual NPI

Incorporated Individual with individual legacy, group legacy, individual NPI and group NPI:

24J – Enter type 1 Individual NPI

33a – Enter type 2 Corporation NPI

Sole Proprietor, not billing for an employee:

24J – Enter nothing

33a – Enter type 1 Individual NPI

Sole Proprietor, billing for an employee:

24J – Enter type 1 Employee individual NPI

33a – Enter type 1 Individual NPI in

Clinics and multiple group offices:

24J – Enter type 1 Individual NPI

33a – Enter type 2 Group NPI

Organizations/Facilities (e.g. ASC, Ambulance, IDTF, etc.):

24J – Enter nothing

33a – Enter type 2 Facility NPI

Provider set up as a group (individual and group legacy) and only one NPI:

Contact Provider Enrollment: (888) 608-8816 [Select Option 1]

Item 24K There is no item 24K on this version.

Provider or Supplier Federal Tax ID (Employer Identification Number)

Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number). *Enter an (X) in the appropriate box to indicate which number is being reported. Only one box can be marked. Do not enter hyphens or spaces.* Medicare providers are not

Item 25 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.

Patient's Account Number

Item 26 **This field is optional** to assist the provider in patient identification. Enter the patient's account number assigned by the provider's of service or supplier's accounting system. As a service, any account numbers entered here will be returned to the provider. *If an account number is entered in this item, it will appear on the provider remittance notice/advice.*

Accept Assignment?

This is a required field, even if you are a participating provider. Check the appropriate *box with an (X)* to indicate whether the provider of service or supplier accepts assignment of Medicare benefits *or not*. 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.

Item 27 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.

Total charges for services on claim

Item 28 Enter *the* total charges for the services (i.e., total of all charges in 24F). *Include the cents with dollar amounts. For example, \$24.00 must be entered as 2400 rather than 24 or 24-. Do not use dollar signs, decimals, dashes, commas, or lines. Negative dollar amounts are not allowed. Do not mark as continued or the claim will be rejected as unprocessable; each CMS-1500 Form should have its own total.*

Total amount the patient paid on the covered services only

Item 29 Enter the total amount the patient paid on the covered services only. *Include the cents with dollar amounts. For example, \$24.00 must be entered as 2400 rather than 24 or 24-. Do not use dollar signs, decimals, dashes, commas, or lines. Negative dollar amounts are not allowed. Do not mark as continued or the claim will be rejected as unprocessable; each CMS-1500 Form should have its own total.*

Do not include the amount paid by the primary insurance, co-insurance, deductibles, account balance, or payments on previous claims in this item.

NOTE: *If any dollar amount is entered here, part or all of the payment will go directly to the patient, even if you are a participating provider.*

Item 30 **Leave blank. Not required by Medicare.**

Signature of Provider of Service or Supplier

This is a required field. Enter the signature of *the* 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, 2008) the form was signed.

Item 31 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. *NAS is unable to process claims without the required*

signature and date listed in item 31. If left blank, the claim will be rejected as unprocessable.

The signature and date must be completely within the confines of this box. Additional acceptable signatures include: Signature stamp and computer generated signature.

Name and Address of Facility Where Services Were Rendered

Enter the name, address, and ZIP code of the facility if the services were furnished in a physician's office, hospital, clinic, laboratory, or facility other than the patient's home. Only one name, address, and ZIP code may be entered in the box. If additional entries are needed, separate claim forms shall be submitted.

Enter the name and address information in the following format:

1st Line – Name

2nd Line – Address

3rd Line – City, State Postal Code, and ZIP Code

NOTE: *Enter a complete address for the location where the services were performed. A PO Box is not acceptable. Do not include telephone numbers, commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between the city and the state postal code. When entering a 9-digit ZIP code, include the hyphen.*

Item 32

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate *CMS-1500 Form* shall be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted 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 carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. When more than one supplier is used, a separate *CMS-1500 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 a modifier is billed, indicating the service was rendered in a Health

Effective May 23, 2008

Only an NPI may be entered in any provider identifier fields on claims submitted on or after May 23, 2008. Claims will be rejected when submitted with a Medicare legacy number (PIN/PTAN) or a UPIN in any provider identifying field on or after May 23, 2008.

ID Qualifier and PIN

Item 32b Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. **Do not report as of May 23, 2008, leave blank.**

Provider's/ Supplier's Telephone Number, Billing Name, Address, and ZIP Code.

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

Item 33

Enter the name and address information in the following format:

1st Line – Name

2nd Line – Address

3rd Line – City, State Postal Code, and ZIP Code

NPI of Billing Provider or Group

This is a required field. Effective May 23, 2008, and later, you **MUST** enter the NPI of the billing provider or group. The NPI may be reported on the *CMS-1500 Form (08-05)* as early as January 1, 2007.

Example:

33. BILLING PROVIDER INFO & PH# (312) 555 2222

*Physician Practice Inc
1234 Healthcare Street
Anytown IL 60610-1234*

Item 33a a. 9876543210 b.

Effective May 23, 2008

Only an NPI may be entered in any provider identifier fields on claims submitted on or after May 23, 2008. Claims will be rejected when submitted with a Medicare legacy number (PIN/PTAN) or a UPIN in any provider identifying field on or after May 23, 2008.

Type 1 is an individual NPI. Type 2 is an organizational NPI.

Incorporated Individual with individual legacy number and individual NPI:

24J – Enter nothing

33a – Enter type 1 Individual NPI

Incorporated Individual with individual legacy, group legacy, individual NPI and group NPI:

24J – Enter type 1 Individual NPI

33a – Enter type 2 Corporation NPI

Sole Proprietor, not billing for an employee:

24J – Enter nothing

33a – Enter type 1 Individual NPI

Sole Proprietor, billing for an employee:

24J – Enter type 1 Employee individual NPI

33a – Enter type 1 Individual NPI in

Clinics and multiple group offices:

24J – Enter type 1 Individual NPI

33a – Enter type 2 Group NPI

Organizations/Facilities (e.g. ASC, Ambulance, IDTF, etc.):

24J – Enter nothing

33a – Enter type 2 Facility NPI

Provider set up as a group (individual and group legacy) and only one NPI:

Contact Provider Enrollment: (888) 608-8816 [Select Option 1]

ID Qualifier and PIN

Item 33b Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. **Effective May 23, 2008, and later, 33b is not to be reported.** Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

Unless otherwise noted, applies to the states of: AZ, MT, ND, SD, UT, WY

© 2008 Noridian Administrative Services, LLC.

[Website Feedback](#) | [Contact Us](#) | [Privacy Policy](#) | [Accessibility Help](#)



[link to CMS](#)