

CMS-1500 Claim Form and Unprocessable/ Rejected Claims

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IMPORTANT



The information provided in this manual was current as of January 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after January 2010, are available at:

<http://www.trailblazerhealth.com/Medicare.aspx>

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MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

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UNPROCESSABLE/REJECTED CLAIMS

Background

CMS continuously strives to reduce costs and administrative waste in the Medicare program. An editing process has been implemented for assigned claims. Since the implementation of this process, millions of dollars are saved each year for the Medicare Trust Fund. For some time, the denial of claims with incomplete or invalid information has resulted in claims surfacing inappropriately into the appeals process. This practice has not only been costly, it has resulted in an inappropriate use of the appeals system.

What Happens?

The current editing process returns paper or electronic claims to the provider as unprocessable if the claim contains certain incomplete or invalid information. No appeal rights are afforded to these claims or a portion of these claims because no "initial determination" could be made; the claim was "unprocessable."

Returned Claims

Please correct "returned" claims promptly because only when this is done will a provider have met his legal obligation for submitting a Medicare claim.

Definitions

Unprocessable Claim – Any claim with incomplete or missing required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

Incomplete Information – Missing, required or conditional information on a claim (e.g., no National Provider Identifier (NPI)).

Invalid Information – Complete required or conditional information on a claim that is illogical or incorrect (e.g., incorrect NPI) or no longer in effect (e.g., an expired number).

Required – Any data element that is needed in order to process a claim (e.g., provider name, date of service).

Not Required – Any data element that is optional or is not needed by Medicare in order to process a claim (e.g., patient's marital status).

Conditional – Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, the primary insurer's group name and number must be entered on a claim or if the insured is different from the patient, the insured's name must be entered on the claim).

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Return as Unprocessable or Return to Provider (RTP) – Returning a claim as unprocessable to the provider does not mean that the contractor will physically return every claim it receives with incomplete or invalid information. The term “Return To Provider (RTP)” is used to refer to the many processes utilized today for notifying the provider or supplier of service that their claim cannot be processed and that it must be corrected or resubmitted. Some (not all) of the various techniques for returning claims as unprocessable include:

- Incomplete or invalid information is detected at the front-end of the contractor claims processing system. The claim is returned to the provider either electronically or in a hardcopy/checklist-type form explaining the error(s) and how to correct the errors prior to resubmission. Claim data is not retained in the system for these RTP claims. No Remittance Advice (RA) is issued.
- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. If requested corrections and/or medical documentation is submitted within a 45-day period, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the RA.
- Incomplete or invalid information is detected within the claims processing system and is rejected through the remittance process. Through the RA, suppliers or providers of service are notified of any error(s) how to correct prior to resubmission. A record of the claim is retained in the system. (Note: This applies to contractors only. FIs do not use the RA process for RTPs.)

A claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied and, as such, is not afforded appeal rights.

Information Provided

If a claim is returned as unprocessable or RTP, the following information will be provided to the provider (if available) to assist with refiling a correct claim:

- Beneficiary’s name.
- Health Insurance Claim (HIC) number.
- Dates of service (MMDDCCYY) (eight-digit format).
- Patient account or control number.
- Explanation of errors (e.g., remittance advice reason and remark codes).

In most cases, reason code 16, “Claims/service lacks information that is needed for adjudication,” will be used in tandem with the appropriate remark code that specifies the missing information. Claims will be returned as unprocessable when the following information is missing.

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Note: This is not an all-inclusive list. Complete unprocessable guidelines can be found on the CMS Web site in the Internet-Only Manual (IOM) Pub. 100-04, Chapter 1, Section 80.3.1 at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

Additional information can be found on the TrailBlazer Health Enterprises® Web site under the CMS-1500 claim form instructions for each of these fields:
<http://www.trailblazerhealth.com/Claims/>.

Required Items		
Field/Item	If:	Remark Code
1a	A claim lacks a valid (or contains an invalid) Health Insurance Claim Number (HICN).	MA61
2	A claim lacks a valid (or contains an invalid) patient's last name and first name as seen on the patient's Medicare card.	MA36
11	A claim does not indicate whether or not a primary insurer to Medicare exists.	MA83 or MA92
12	A claim lacks a valid (or contains an invalid) patient or authorized person's signature.	MA75
24a	A claim lacks a valid (or contains an invalid) "from" date of service.	M52
24b	A claim lacks a valid (or contains an invalid) place of service for each detail.	M77
24d	A claim lacks a valid (or contains an invalid) procedure or HCPCS code.	M20 or M51
24f	A claim lacks a charge for each listed service.	M79
24g	If the claim does not indicate at least one day or unit	M53
31	A claim lacks a signature from a provider of service or supplier, or their representative.	MA70 or MA81
33	A claim does not contain a billing name, address, ZIP code and telephone number of a provider or supplier of service and a valid NPI in Item 33a.	N256, N257, N258 or MA112
33a	A claim lacks the NPI of the billing provider, supplier or group.	N257 or MA112

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Conditional Items		
Field/Item	If:	Remark Code
4, 6 and 7	A primary insurer is indicated in Item 11, but Items 4, 6 and 7 are incomplete.	MA64, MA88, MA89 or MA92
11c	There is an insurance primary to Medicare and the plan name or program name is missing.	MA92 or N245
14	Chiropractic service is billed, but does not contain a date actual treatment occurred.	MA122
17, and 17b	A service was ordered or referred and the name and NPI are not entered. Effective May 23, 2008, if a claim contains a legacy provider identifier.	N264, N269, N270, N285 or N286 N257
19	<ul style="list-style-type: none"> • Routine foot care. • Unlisted/NOC procedure code. • Homebound. 	N324 or N253 M51 MA116
20	<ul style="list-style-type: none"> • A diagnostic test is subject to purchase price limitations and “Yes” or “No” is not indicated on the claim. • The “Yes” box is checked but the supplier’s name, address, ZIP code and NPI are not entered in Item 32. • <i>Refer to “Diagnostic Test Subject to Anti-Markup Payment Limitations” in this manual.</i> 	M12 or MA111 N256, N257 or N258 <i>MA110</i>
21	The diagnosis is missing, incorrect, truncated or a narrative diagnosis was not provided as an attachment.	M81 or M76
23	<ul style="list-style-type: none"> • For all physician office laboratory claims – If a 10-digit CLIA laboratory identification number is not present. • The Investigational Device Exemption (IDE) number is not present. • Ambulance companies must enter a five-digit ZIP code for point of pickup. 	MA120 MA50 N53
24a	A date of service extends more than one day and a valid “to” date is not entered.	M59
24d	HCPSC modifier (which must be associated with a HCPSC procedure code) is invalid or obsolete.	M20
24j	Group/clinic is billing and the rendering/attending physician’s NPI is not entered.	MA112

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32	The name, address and ZIP code of facility where the service was furnished are missing.	MA114
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Diagnostic Test Subject to [Anti-Markup Payment Limitations \(Item 20\)](#)

The Technical Component (TC) and Professional Component (PC) of diagnostic tests subject to the anti-markup payment limitation:

- If a “YES” or “NO” is not indicated in Item 20 and no acquisition price is entered under the word “\$CHARGES.” A/B Medicare Administrative Contractors (MACs) shall assume the service is not subject to the anti-markup payment limitations.
- If a “YES” or “NO” is not indicated in Item 20 and an acquisition price is entered under the word “\$CHARGES.”
- If the “YES” box is checked in Item 20 and a required acquisition price is not entered under the word “\$CHARGES.”
- If the “NO” box is checked in Item 20 and an acquisition price is entered under the word “\$CHARGES.”

Claims will reject as unprocessable for diagnostic test [subject to the anti-markup payment](#) limitations if:

Paper Claims:

- The “Yes” box is checked in Item 20, and more than one test is billed on the claim.
- Both the interpretation and test are billed on the same claim, and the dates of service and places of service do not match.
- The “Yes” box is checked in Item 20, both the interpretation and test are submitted, and the date of service and place of service do not match.
- The “Yes” box is checked in Item 20 and the service is billed using a global code rather than having each component billed as a separate line item.

Electronic:

- There is an indication on the claim that a test [is subject to the anti-markup payment](#) limitations, more than one test is billed on the claim and line level information for each total purchased service amount is not submitted for each test.
- There is an indication on the claim that a test [is subject to the anti-markup payment](#) limitations, and the service is billed using a global code rather than having each component billed as a separate line item.

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ICD-9-CM Coding and Returned Claims

Impact on ICD-9-CM Coding

Claims for physicians' services submitted on or after July 1, 2005, with a truncated ICD-9-CM diagnosis code for the date of service given will be "returned as unprocessable."

Important Note: It is imperative to use the most recent version of the ICD-9-CM coding book.

CMS has eliminated the 90-day grace period from October 1 through December 31 for billing discontinued ICD-9-CM codes. Providers will be required to use the new codes.

Fourth or Fifth Digits

Do not add or substitute numbers where they do not already exist in the coding scheme. For example, there are some legitimate three-digit ICD-9-CM codes that do not have a fourth or fifth digit. Physician offices should not add zeroes to these codes. The codes selected should accurately describe a patient's illness or disease and be listed in the latest ICD-9-CM edition.

Frequently Truncated Codes

Some examples of the most frequently truncated diagnosis codes are:

- Code 250 (diabetes mellitus) requires five digits. The fourth digit must be 0 through 9; the fifth digit must be 0 through 3.
- Code 200 (lymphosarcoma and reticulosarcoma) requires five digits. The fourth digit must be 0, 1, 2 or 8; the fifth digit must be 0 through 8.
- In the case of hypertensive disease, use code 4010 for malignant essential hypertension and code 4011 for benign essential hypertension. There is no fifth digit available for essential hypertension in the current coding system. Use code 40210 for benign hypertensive heart disease without congestive heart failure and code 40211 for benign hypertensive heart disease with congestive heart failure.
- Code 185 (malignant neoplasm of prostate). Do not add a zero; 1850 is incorrect.
- Code 496 (COPD). Do not add a zero; 4960 is incorrect.

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CMS-1500 CLAIM FORM

The CMS-1500 claim form and its instructions are available at:

<http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf>

Health Insurance Claim (HIC) Number

Traditional

All claims require the complete Health Insurance Claim (HIC) number in Item 1a of the CMS-1500 claim form or in the appropriate field for electronic claims.

Enter the patient's Medicare HIC number exactly as it appears on the patient's Medicare card whether Medicare is the primary or secondary payer. Enter the number without spaces and/or hyphens.

The HIC number should be nine digits followed by a valid suffix.

Example: # # # # # # # # A

The following are examples of valid HIC number suffixes:

Code	Type
A	Wage earner (retirement)
B	Wife
B1	Husband
C1–C9	Child (includes disabled or student child)
D	Aged widow
D1	Widower
E1	Surviving divorced mother
E5	Surviving divorced father
G	Claimant of lump-sum death benefits
M	Uninsured – premium health insurance benefits (Part A)
M1	Uninsured – qualified for but refused HIB (Part A)
T	Uninsured – entitled to HIB (Part A) under deemed or renal provisions
W	Disabled widow
W1	Disabled widower

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Railroad Retirement

These beneficiaries have a prefix in front of the HIC number instead of a suffix after it. The number itself has either six digits or the regular nine digits.

Example: A # # # # # # # #

Send claims for railroad retirees to Palmetto GBA – Railroad Medicare, P.O. Box 10066, Augusta, GA 30999-0001. **Do not send these claims to TrailBlazerSM.**

Exception: Send Indian Health claims for railroad retirees to TrailBlazer Health Enterprises, LLC, P.O. Box 660159, Dallas, TX 75066-0159.

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Completion Instructions

Item 1 Show the type of health insurance coverage applicable to this claim by checking the appropriate box.

If filing a Medicare claim, check the Medicare box.

 Paper:

1. MEDICARE <input checked="" type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/>	CHAMPVA (MemberID#) <input type="checkbox"/>	GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>	FECA BLK LUNG (SSN) <input type="checkbox"/>	OTHER (ID) <input type="checkbox"/>
---	---	---	--	---	---	---

 Electronic:

2000B	SBR09	Medicare Indicator
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Item 1a* Enter the patient's Medicare HIC number whether Medicare is the primary or secondary payer.

Use the number shown on the Medicare card.

 Paper:

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

 Electronic:

2010BA	NM101	Insured or Subscriber
	NM102	Person
	NM108	Medicare Identification Number
	NM109	Medicare Primary Identifier

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Item 2* Enter the patient's last name, first name and middle initial, if any, as shown on the patient's Medicare card.

Use the name as it appears on the Medicare card.

 Paper:

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

 Electronic:

2010BA	NM103	Last Name
	NM104	First Name
	NM105	Middle Name

Item 3 Enter the patient's eight-digit birth date (MM/DD/CCYY) and sex.

 Paper:

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY	M	F
##	##	####	<input checked="" type="checkbox"/>	<input type="checkbox"/>

 Electronic:

2010BA	DMG02	Birth Date
	DMG03	Gender

Item 4+ If the patient has insurance primary to Medicare, either through the patient 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.

If there is insurance primary to Medicare, list the name of the insured here. If the insured and patient are the same, enter the word "Same."

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 Paper:

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

If Medicare is primary, leave this field blank.

 Electronic:

2330A	NM103	Last Name
	NM104	First Name
	NM105	Middle Name
	NM107	Suffix (e.g., Jr., Sr.)

Item 5 Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.

 Paper:

- A – Street address.**
- B – City and state.**
- C – ZIP code and phone number**

5. PATIENT'S ADDRESS (No., Street)	
### Main Street	
CITY Anytown	STATE TX
ZIP CODE #####	TELEPHONE (Include Area Code) (###) ### - ####

 Electronic:

2010BA	N301	Address Line 1
	N302	Address Line 2
	N401	City Name
	N402	State Code
	N402	ZIP Code

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Item 6+ Check the appropriate box for patient's relationship to insured when Item 4 is completed.

 Paper:

6. PATIENT RELATIONSHIP TO INSURED			
Self	<input type="checkbox"/>	Spouse	<input type="checkbox"/>
Child	<input type="checkbox"/>	Other	<input type="checkbox"/>

 Electronic:

2000B or 2320	SBR02	Self Relationship
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Item 7+ 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.

- A. If Medicare is secondary, enter the street address on the first line, the city and state on the second line, and the ZIP code and phone number on the third line.**
- B. When the address is the same as the patient's, enter the word "Same." Complete this item only when Items 4 and 11 are completed.**
- C. If Medicare is primary, leave blank.**

 Paper:

7. INSURED'S ADDRESS (No., Street)

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Electronic:

2330A	N301	Address Line 1
	N302	Address Line 2
	N401	City Name
	N402	State Code
	N403	ZIP Code

Item 8

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



Paper:

8. PATIENT STATUS					
Single	<input type="checkbox"/>	Married	<input type="checkbox"/>	Other	<input type="checkbox"/>
Employed	<input type="checkbox"/>	Full-Time Student	<input type="checkbox"/>	Part-Time Student	<input type="checkbox"/>



Electronic:

Not Mapped

Item 9

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.

Note: Only participating physicians and suppliers should complete Item 9 and its subdivisions and only when the beneficiary wishes to assign his 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 benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

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Medigap – Medigap policy meets the statutory definition of a “Medicare supplemental policy” contained in Section 1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation, which 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 people 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 contractor to send Medicare claim information electronically. If there is no such contact, the beneficiary must file his own supplemental claim.

If you are a participating provider or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in Items 9, 9a, 9b and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information to the Medigap insurer.

- A. If the insured’s name is different than Item 2, enter the last name, first name and middle initial of the enrollee.**
- B. If the insured’s name is the same as Item 2, enter the word “Same.”**
- C. If no Medigap benefits are assigned, leave blank.**

 Paper:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe John or SAME

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Electronic:

2330A	NM103	Last Name
	NM104	First Name
	NM105	Middle Name
	NM107	Suffix (e.g., Jr., Sr.)

Item 9a

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

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

A. Enter MEDIGAP, MG or MGAP.

B. Enter the policy and/or group number of the Medigap insured.



Paper:

a. OTHER INSURED'S POLICY OR GROUP NUMBER MG #####



Electronic:

2330A or 2320	NM109	Insured's Identifier
	SBR03	Insured's Group or Policy Number

Item 9b

Enter the Medigap insured's eight-digit birth date (MM/DD/CCYY) and sex.



Paper:

b. OTHER INSURED'S DATE OF BIRTH			SEX		
MM	DD	YY	M	<input checked="" type="checkbox"/>	F
##	##	####			

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Electronic:

2320	DMG02	Birth Date
	DMG03	Gender

Item 9c

Leave blank if a Medigap Payer ID is entered in Item 9d. 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.

Example:

1257 Anywhere Street
Baltimore, MD 21204

Is Shown As:

1257 Anywhere St., MD 21204



Paper:

c. EMPLOYER'S NAME OR SCHOOL NAME



Electronic:

Not Mapped

Item 9d

Enter the nine-digit PAYER ID number of the Medigap insurer. If no PAYER ID number exists, enter the Medigap insurance program or plan name.

Note: Effective October 1, 2007, enter the new five-byte Coordination of Benefits Agreement (COBA) Medigap claim-based ID (range 55000 to 59999). The Medigap claim-based ID spreadsheet can be found at: <http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf>.

Additional information can be found in MLN Matters® article SE 0743 at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf>.

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 Paper:

d. INSURANCE PLAN NAME OR PROGRAM NAME #####

 Electronic:

2330B	NM109	Payer Primary Identifier
	NM103	Payer Last Name or Organization Name
2320	SBR04	Insured's Group Name

Items 10a–10c 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.

 Paper:

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. AUTO ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO PLACE (State)
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

 Electronic:

2330	CLM11-1	AA = Auto Accident
	CLM11-2	AP = Another Party Responsibility
	CLM11-3	EM = Employment
	CLM11-4	OA = Other Accident
		Auto Accident State Code

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Item 10d Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

 Paper:

10d. RESERVED FOR LOCAL USE

 Electronic:

2330A NM109 Medicaid Identification Number

Item 11* **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.**

 Paper:

If Medicare is secondary, enter the insured's policy or group number.

11. INSURED'S POLICY GROUP OR FECA NUMBER

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.

11. INSURED'S POLICY GROUP OR FECA NUMBER

NONE

If the insured reports a terminating event with regard to insurance that had been primary to Medicare (e.g., insured retired), enter the word "**None**" and proceed to Item 11b.

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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 of the CMS-1500 claim 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.
 - Disability (large group health plan).
 - End stage renal disease.
 - No-fault and/or other liability.
- Work-related illness/injury:
 - Workers’ Compensation.
 - Black lung.
 - Veterans’ benefits.

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.



Electronic:

2320	SBR01	Payer Responsibility
	SBR03	Insured’s Group or Policy Number
2330A	NM108	MI = Member Identification Number
	NM109	Subscriber’s Identification Number
2000B	SBR05	Insurance Type Code
2000B or 2320	SBR09	Claim Filing Indicator Code

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Item 11a Enter the insured's eight-digit birth date (MM/DD/CCYY) and sex if different from Item 3.

 Paper:

a. INSURED'S DATE OF BIRTH			SEX	
MM	DD	YY	M	F
##	##	####	<input checked="" type="checkbox"/>	<input type="checkbox"/>

 Electronic:

2320	DMG01	Date Time Period Format Qualifier
	DMG02	Birth Date
	DMG03	Gender

Item 11b+ Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a six-digit (MM/DD/YY) or eight-digit retirement date (MM/DD/CCYY) preceded by the word "**Retired.**"

 Paper:

A. Enter employer's name, if applicable.

b. EMPLOYER'S NAME OR SCHOOL NAME
ABC Factory

B. Enter a six- or eight-digit retirement date preceded by the word "Retired."

c. INSURANCE PLAN NAME OR PROGRAM NAME
RETIRED ##/##/#### or ##/##/##

 Electronic:

Not Mapped

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Item 11c+ Enter the nine-digit PAYER ID number of the primary insured. If no PAYER ID number exists, enter the **complete** primary payer's program name 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.**

Note: The nine-digit PAYERID number indicated in this instruction has not been implemented by CMS at this time and no other payer ID numbers are acceptable. When there is an insurance primary to Medicare, the information that needs to be submitted in Item 11c of the CMS-1500 claim form is the insurance plan name. If anything other than the plan name is submitted in Item 11c, the claims will be rejected by Medicare.

 Paper:

A. Enter the nine-digit PAYER ID number of the primary insurer.

c. INSURANCE PLAN NAME OR PROGRAM NAME #####

B. If no PAYER ID exists, enter the complete primary payer's program name or plan name.

c. INSURANCE PLAN NAME OR PROGRAM NAME BCBSTX
--

 Electronic:

2320	SBR04	Other Insured's Group Name
------	-------	----------------------------

Item 11d Leave blank. Not required by Medicare

 Paper:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>
--

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

Leave Blank – Not Used by Medicare

Item 12*

The patient or authorized representative must sign and enter either a six-digit date (MM/DD/YY), an eight-digit date (MM/DD/CCYY) or an alphanumeric date (e.g., January 1, 2005) 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" of the Internet-Only Manual (IOM) Pub. 100-04. 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.

Note: This can be "Signature on File" for paper or electronic claims. A computer-generated signature will be accepted for electronic claims only.

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 name and address next to the mark.



Paper:

A. The patient or authorized representative signature and either a six- or eight-digit date.

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 <u>John Doe</u>	DATE <u>##/##/####</u>

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

B. Medicare will accept “signature on file.” Medicare will accept a computer-generated signature for electronic claims only.

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 <i>Signature on File</i>	DATE ##/##/####



Electronic:

2300	CLM08	Condition or Response Code
	CLM09	Release of Information Code
	CLM10	Patient's Signature Code

Item 13

Currently, 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 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 indicate that the authorization applies to all occasions of service until it is revoked.

Effective April 1, 2008, 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 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 providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

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 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" for paper or electronic claims. A computer-generated signature will be accepted for electronic claims only.

 Paper:

A. Patient's signature authorizing release of Medigap information.

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 <i>John Doe</i>

B. Medicare will accept "signature on file." Medicare will accept a computer-generated signature for electronic claims only.

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 <i>Signature on File</i>
--

C. If no Medigap benefits exist, leave blank.

 Electronic:

2320	Q103	Assignment of Benefits Indicator
	Q104	Patient's Signature Code
	Q106	Release of Information Code

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Items 14–33 – Provider of Service or Supplier Information

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

Item 14+ Enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/CCYY) date of current illness, injury or pregnancy. For chiropractic services, enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/CCYY) date of the initiation of the course of treatment and enter an eight-digit (MM/DD/CCYY) or six-digit (MM/DD/YY) date in Item 19.

Enter a six- or eight-digit date.

 Paper:

14. DATE OF CURRENT: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;">MM</td> <td style="width: 15%; text-align: center;">DD</td> <td style="width: 15%; text-align: center;">YY</td> <td style="width: 55%;"></td> </tr> <tr> <td style="text-align: center;"># #</td> <td style="text-align: center;"># #</td> <td style="text-align: center;"># # # #</td> <td></td> </tr> </table>	MM	DD	YY		# #	# #	# # # #		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
MM	DD	YY							
# #	# #	# # # #							

 Electronic:

2300	DTP01	439 = Accident Qualifier
	DTP03	Accident Date
2300 or 2400	DTP01	431 = Onset of Current Illness or Injury
	DTP03	Date of Current Illness or Injury
	DTP01	454 = Initial Treatment Date (Chiropractors)
	DTP03	Date of Initial Treatment

Item 15 Leave blank. Not required by Medicare.

 Paper:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	MM	DD	YY

 Electronic:

Leave Blank – Not Used by Medicare

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 16 If the patient is employed and is unable to work in his current occupation, enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/CCYY) date when patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

 Paper:

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

 Electronic:

2300	DTP01	360 = Disability Begin Date and/or 361 = Disability End Date
	DTP03	Disability Begin and/or End Date

Item 17+ 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 or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 must be used for each ordering/referring physician.

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

Ordering physician: A physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services or durable medical equipment and services “incident to” that physician’s or non-physician practitioner’s service. See Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15 for non-physician practitioner rules.

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 Item 17b below for further guidance on reporting the referring/ordering provider’s NPI.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

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 service.
- 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 and NPI of the physician who is supervising the limited licensed practitioner.



Paper:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE John Q. Public
--



Electronic:

2310A or 2420F	NM101	DN = Referring Provider
	NM102	Entity Type Qualifier
	NM103	Referring Provider Last Name
	NM104	Referring Provider First Name
	NM105	Referring Provider Middle Name
2420E	NM101	DK = Ordering Provider
	NM102	Entity Type Qualifier
	NM103	Ordering Provider Last Name
	NM104	Ordering Provider First Name
	NM105	Ordering Provider Middle Name

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

The term “physician” when used within the meaning of Section 1861(r) of the Social Security Act and used in connection with performing any function or action, refers to:

- A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he performs such function or action.
- A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state in which he performs such functions and who is acting within the scope of his license when performing such functions.
- A doctor of podiatric medicine for purposes of subsections (k), (m), (p)(1) and (s) and Sections 1814(a), 1832(a)(2)(F)(ii) and 1835 of the Act, but only with respect to functions that he is legally authorized to perform by the state in which he performs them.
- A doctor of optometry, but only with respect to the provision of items or services described in Section 1861(s) of the Act that he is legally authorized to perform as a doctor of optometry by the state in which he performs them.

Or,

- A chiropractor who is licensed as such by a state (or in a state that does not license chiropractors as such) and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services and who meets uniform minimum standards specified by the Secretary, but only for purposes of Sections 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 Section 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 Section 1862(a)(4) of the Act) are furnished.

Per Change Request (CR) 6417, effective October 1, 2009, only the following providers can order/refer beneficiary services:

- Doctor of medicine or osteopathy.
- Dental medicine.
- Dental surgery.
- Podiatric medicine.
- Optometrist.
- Chiropractic medicine.
- Physician assistant.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

- Certified clinical nurse specialist.
- Nurse practitioner.
- Clinical psychologist.
- Certified nurse midwife.
- Clinical social worker.

Item 17a+ Effective May 23, 2008, this field is no longer used.

Item 17b+ Enter the NPI of the referring/ordering physician listed in Item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

 Paper:

17b.	NPI	#####
------	-----	-------

 Electronic:

2310A or 2024F	NM108	XX = NPI Qualifier
	NM109	NPI for Referring Physician (NM101 = DN)
2420E	NM108	XX = NPI Qualifier
	NM109	NPI of Ordering Physician (NM101 = DK)

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

Enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/CCYY) date.

 Paper:

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

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2300	DTP01	435 = Admission or 096 = Discharge
	DTP03	Date of Admit or Discharge

Item 19+ Narrative Field

A. Routine Foot Care

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



Paper:

19. RESERVED FOR LOCAL USE
Date Last Seen (## / ## / ##) and NPI Number



Electronic:

2300 or 2400	DTP01	304 = Routine Foot Care Qualifier
	DTP02	D8 = Date Format That Will Appear in DTP03
	DTP03	Date Last Seen
2310E or 2420D	NM101	DQ = Supervising Physician
	NM102	1 = Person
	NM103	Last Name or Organization Name
	NM104	First Name
	NM105	Middle Name, 106 = Prefix, 107 = Suffix
	NM108	XX = NPI Qualifier
NM109	NPI Number	

B. Independent Physical or Occupational Therapist Services

For physical and occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If the information is submitted voluntarily, it must be correct or it

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

will cause rejection or denial of the claim. However, when the therapy service is provided “incident to” the services of a physician or non-physician practitioner, then “incident to” policies continue to apply. For example, for identification of the ordering who provided the initial service, see Items 17 and 17b, and for the identification of the supervisor, see Item 24j of this section.

Enter either a six- or eight-digit date patient was last seen and the NPI of his attending physician.

 Paper:

19. RESERVED FOR LOCAL USE Date Last Seen (## / ## / ##) and NPI Number
--

 Electronic:

Not required at this time

C. Chiropractor Treatment

Enter either a six-digit (MM/DD/YY) or an eight-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 contractor review.

 Paper:

19. RESERVED FOR LOCAL USE ## / ## / ## (X-ray Date for Chiropractor)
--

 Electronic:

2300 or 2400	DTP01	455 = Last X-ray Date
	DTP02	D8 = Date Format Qualifier for DTP03
	DTP03	Date Last Seen for Chiropractor

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

D. Not Otherwise Classified (NOC) Drugs

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter the name of the drug and dosage.

 Paper:

19. RESERVED FOR LOCAL USE
Bupivacaine 10 ml or Bupivacaine 3 ml

 Electronic:

2300 or 2400	NTE01	ADD = Additional Information
	NTE02	Drug Name and Dosage

E. Unlisted Procedure Code or an NOC Code

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

 Paper:

19. RESERVED FOR LOCAL USE
Description of NOC procedure code

 Electronic:

2300 or 2400	NTE01	ADD = Additional Information
	NTE02	Description or NOC Code

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

F. Multiple Modifiers per 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. (Only required when billing five or more modifiers.)

List all modifiers associated with the line item.

 Paper:

19. RESERVED FOR LOCAL USE 1 = Q8, T1, T2, T3, T4
--

 Electronic:

2300 or 2400	NTE01	ADD = Additional Information
	NTE02	List Extra Modifiers

G. Homebound or Institutionalized Patient

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 word “Homebound.”

 Paper:

19. RESERVED FOR LOCAL USE Homebound

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CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2300	CRC01	75 = Functional Limitations
	CRC02	Y = Certification Condition Indicator
	CRC03	IH = Independent at Home

H. Beneficiary Refuses to Assign Benefits

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 statement "Patient refuses to assign benefits."



Paper:

19. RESERVED FOR LOCAL USE Patient refuses to assign benefits
--



Electronic:

2300	CLM07	P = Patient Refuses to Assign Benefits
------	-------	--

I. Hearing Aid

Enter the statement, "Testing for hearing aid," when billing services involving the testing of a hearing aid(s), which is used to obtain intentional denials when other payers are involved.

Enter statement "Testing for hearing aid."



Paper:

19. RESERVED FOR LOCAL USE Testing for hearing aid

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CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2300 or 2400	NTE01	ADD = Additional Information
	NTE02	Enter Statement "testing for hearing aid"

J. Dental Examination

When dental examinations are billed, enter the specific surgery for which the exam is being performed.



Paper:

19. RESERVED FOR LOCAL USE Specific surgery for which the exam is being performed
--



Electronic:

2300 or 2400	NTE01	ADD = Additional Information
	NTE02	List the Specific Surgery for Which the Exam Is Being Performed

K. Shared Postoperative Care

Enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/CCYY) assumed and/or relinquished date for a global surgery claim when providers share postoperative care.



Paper:

19. RESERVED FOR LOCAL USE ##/##/#### (Date assumed care of date relinquished care)
--



Electronic:

2300	DTP01	90 = Report Start, 91 = Report End
	DTP02	D8 = Date Format Qualifier for DTP03
	DTP03	Date for Global Surgery

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

L. Demonstration

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

 Paper:

19. RESERVED FOR LOCAL USE 30 demonstration ID number
--

 Electronic:

2300	REF01	P4 = Project Code
	REF02	ID Number "30" for All National Emphysema Trials

M. Purchased Interpretation

Enter the NPI 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).

 Paper:

19. RESERVED FOR LOCAL USE NPI of the performing physician

 Electronic:

2310C or 2420B	NM101	QB = Purchase Service Provider
	NM102	1 = Person
	NM103	Last Name or Organization Name
	NM104	First Name
	NM105	Middle Name, 106 = Prefix, 107 = Suffix
	NM108	XX = NPI Qualifier
	NM109	NPI Number

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

N. Hematocrit (HCT)/Hemoglobin

Method II suppliers shall enter the most current Hematocrit (HCT) value for the injection of Aranesp[®] for End Stage Renal Disease (ESRD) beneficiaries on dialysis (see Pub. 100-04, Chapter 8, Section 60.7.2).

Individuals and entities who bill contractors or A/B Medicare Administrative Contractors (MACs) for administration of Erythropoiesis Stimulating Agents (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 three numerics and a decimal point [xx.x]. Example for hemoglobin tests: TR/R1/9.0, Example for hematocrit tests: TR/R2/27.0.

 Paper:

19. RESERVED FOR LOCAL USE

TR/R1/10.5

 Electronic:

2400	DTP01	738 = Hemoglobin or Hematocrit or Both 739 = Serum Creatine
	DTP02	D8 = Date Format That Will Appear in DTP03
	DTP03	Date of Hemoglobin, Hematocrit or Creatine
	MEA01	TR = Test Results
	MEA02	R1 = Hemoglobin or R2 = Hematocrit or R4 = Creatine
	MEA03	Measurement Values (e.g., XX.X)

O. Fax/Mail Documentation (Electronic Only)

Enter a statement indicating the medical records were sent to the Medicare contractor in advance.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

 Electronic:

2300 or 2400	NTE01	ADD = Additional Information
	NTE02	Date Documentation Was Faxed or Mailed

Item 20+

Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase 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 purchased tests are included on the claim.” When “Yes” is marked, Item 32 shall be completed.

No purchase tests are included on the claim.

 Paper:

20. OUTSIDE LAB?	\$ CHARGES
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

Yes – Enter the amount of the purchased test.

20. OUTSIDE LAB?	\$ CHARGES
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	25 00

 Electronic:

2400	PS101	Purchased Service Reference Number
	PS102	Purchased Service Charge Amount

When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate Form CMS-1500. Multiple purchased 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.

Note: This is a required field when billing for diagnostic tests subject to purchase price limitations.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 21+ 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., physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists) shall use an ICD-9-CM code number and code to the highest level of specificity for that date of service. Enter codes in priority order (primary, secondary condition).

All narrative diagnoses for non-physician specialties shall be submitted on an attachment.

Enter diagnosis codes and code to the highest level of care for the date of service.

 Paper:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			
1.	98488	3.	
2.	84219	4.	

 Electronic:

2300	HI01-1	BK = Principal Diagnosis
	HI01-2	Primary Diagnosis Code
	HI02-1	BF = Diagnosis Code
	HI02-2	2nd Diagnosis Code
	HI03-1	BF = Diagnosis Code
	HI03-2	3rd Diagnosis Code
	HI04-1	BF = Diagnosis Code
	HI04-2	4th Diagnosis Code
	HI05-1	BF = Diagnosis Code
	HI05-2	5th Diagnosis Code
	HI06-1	BF = Diagnosis Code
	HI06-2	6th Diagnosis Code
	HI07-1	BF = Diagnosis Code
	HI07-2	7th Diagnosis Code
	HI08-1	BF = Diagnosis Code
	HI08-2	8th Diagnosis Code

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 22 Leave blank. Not required by Medicare.

Item 23+ Prior Authorization Number

- A. Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.**
- B. 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.**
- C. For physicians performing Care Plan Oversight (CPO) services, enter the six-digit Medicare provider number of the Home Health Agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.**

Note: Until further notice, do not submit an HHA or hospice provider number when billing for CPO services. Submission of the home health or hospice provider number will result in the services being returned as unprocessable. Further information can be found in Pub. 100-04, Transmittal 999, Change Request 4374.



Paper:

23. PRIOR AUTHORIZATION NUMBER #####



Electronic:

2300	REF01	G1 = Prior Authorization Qualifier (QIO)
	REF02	Prior Authorization Number
	REF01	LX = Qualified Products Lists
	REF02	Investigational Device Exemption (IDE) Number
2310D or 2420C	NM101	Home Health/Hospice Number. Until further notice, DO NOT submit a Home Health Agency (HHA) or hospice provider number when billing CPO services.
	NM108	
	NM109	
	REF01	
	REF02	

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

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

Enter the 10-digit CLIA number.

 Paper:

23. PRIOR AUTHORIZATION NUMBER ##### (10 digit CLIA number)
--

 Electronic:

2300 or 2400	REF01	X4 = CLIA Reference Qualifier
	REF02	CLIA Certification Number

E. Ambulance companies must enter a single five-digit ZIP code for the point of pickup.

Point of pickup five-digit ZIP code.

 Paper:

23. PRIOR AUTHORIZATION NUMBER ##### (5 digit ZIP number)
--

 Electronic:

2420C	N403	ZIP Code – Ambulance Point of Pickup
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Item 24

The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifiers 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.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

When required to submit National Drug Codes (NDCs), drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in position 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC code. 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).

 Paper only:

24. A. DATE(S) OF SERVICE			B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER					
N4	00	26	08	04	27	Immune Globulin Intravenous	UN2					
											NPI	

Item 24a* Enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/CCYY) 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.

 Paper:

Enter either a six-digit or eight-digit date for each procedure, service or supply.

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
08	01	07			

When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in Item 24g.

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
08	01	07	08	05	07

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2400	DTP01	472 = Service Qualifier
	DTP02	D8 = Date Format That Will Appear in DTP03
	DTP03	Date for Each Procedure

Item 24b*

Enter the appropriate place of service code(s) from the list provided. Identify the location using a place of service code for each item used or service performed.

Identify the location, using a place of service code, for each item used or service performed.



Paper:

B. PLACE OF SERVICE
11



Electronic:

2300	CLM05-1	Place of Service (Header)
2400	SV105	Place of Service (Detail)

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

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Places of Service

The following are the only places of service the Medicare program can accept.

- 01 Pharmacy
- 03 School
- 04 Homeless Shelter
- 05 Indian Health Service Freestanding Facility (not applicable for adjudication)
- 06 Indian Health Service Provider-Based Facility (not applicable for adjudication)
- 07 Tribal 638 Freestanding Facility (not applicable for adjudication)
- 08 Tribal 638 Provider-Based Facility (not applicable for adjudication)
- 09 Prison/Correctional Facility Setting
- 11 Office
- 12 Home
- 13 Assisted-Living Facility
- 14 Group Home
- 15 Mobile Unit
- 16 Temporary Lodging – Effective April 1, 2008.
- 20 Urgent Care Facility
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room – Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance – Land
- 42 Ambulance – Air or Water
- 49 Independent Clinic
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 57 Non-Residential Substance Abuse Treatment Facility
- 60 Mass Immunization Center
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 24c Medicare providers are not required to complete this item.

Item 24d* Enter the procedures, services or supplies using the CMS HCPCS code. When applicable, show HCPCS code modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when reporting an “unlisted procedure code” or as 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 and allows up to four modifiers.

Enter the specific procedure code.



Paper:

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
CPT/HCPCS	MODIFIER			
73100	26			



Electronic:

2400	SV101-1	HC = For HCPCS Service ID Qualifier
	SV101-2	Procedure Code
	SV101-3	Procedure Modifier 1
	SV101-4	Procedure Modifier 2
	SV101-5	Procedure Modifier 3
	SV101-6	Procedure Modifier 4

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 24e* 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: 1, 2, 3 or 4. This is a required field.

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.

Although the 1500 instructions state up to four (4) diagnoses can be submitted on a CMS-1500 form, CR 5441 allows providers to bill up to eight (8) diagnoses on a claim.

Enter only one reference number per line item.

 Paper:

E. DIAGNOSIS POINTER
1

 Electronic:

2400	SV107-1	1st Diagnosis Code Pointer
	SV107-2	2nd Diagnosis Code Pointer
	SV107-3	3rd Diagnosis Code Pointer
	SV107-4	4th Diagnosis Code Pointer

Item 24f* Enter the charge for each listed service.

Charge amount for each service.

 Paper:

F. \$ CHARGES
100 00

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2400	SV102	Line Item Charge Amount
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Item 24g*

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.



Paper:

G. DAYS OR UNITS
2



Electronic:

2400	SV103	UN = Unit, MJ = Minutes, F2 = International
	SV104	Enter Number of Days, Units or Minutes

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 Internet-Only Manual (IOM) Pub 100-04, Chapter 20, Section 130.6 on the CMS Web site.

Item 24h Leave blank. Not required by Medicare.

Item 24i Leave blank. Not required by Medicare.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 24j+ 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 portion of this field.

Note: Shaded portion should not be used.

 Paper:

J. RENDERING PROVIDER ID. #
Not Used
#####

 Electronic:

2310B	NM101	82 = Rendering Provider Qualifier
or	NM108	XX = NPI Qualifier
2420A	NM109	NPI Number

Item 25 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 Coordination of Benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate NPI reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

 Paper:

25. FEDERAL TAX I.D. NUMBER	SSN EIN
## - #####	<input type="checkbox"/> <input type="checkbox"/>

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CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2010AA or 2010AB	REF01	EI = Tax ID or SY – Social Security Qualifier
	REF02	Tax ID Number or Social Security Number

Item 26

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



Paper:

26. PATIENT'S ACCOUNT NO.



Electronic:

2300	CLM01	Provider Assigned Account Number
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Item 27

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 must accept assignment of Medicare benefits of all covered charges for all patients.



Paper:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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CMS-1500 Claim Form and Unprocessable/Rejected Claims



Electronic:

2300	CLM07	A = Assigned
		B = Assignment Accepted on Clinical Lab Only
		C = Not Assigned
		P = Patient Refuses to Assign Benefits

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 (ASC) services for covered ASC procedures.
- Home dialysis supplies and equipment paid under Method II.
- Ambulance services.
- Drugs and biologicals.
- Simplified billing roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 Enter total charges for the services (i.e., total of all charges in Item 24f).



Paper:

28. TOTAL CHARGE
\$ 200 00



Electronic:

2300	CLM02	Total Charge Amount for All Services
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MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Item 29 Enter the total amount the patient paid on the covered services only.

 Paper:

29. AMOUNT PAID
\$ _____

 Electronic:

2300	AMT01	F5 = Patient Paid Amount Qualifier
	AMT02	Patient Paid Amount

Item 30 Leave blank. Not required by Medicare.

Item 31* Enter the signature of the provider of service or supplier, or his representative, and either a six-digit date (MM/DD/YY), eight-digit date (MM/DD/CCYY) or alphanumeric date (e.g., January 1, 2005) the form was signed.

 Paper:

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.)	
<i>John Smith</i>	##/##/####
SIGNED	DATE

 Electronic:

2300	CLM06	Y = Signature on File
		N = Signature Not on File

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, enter the signature of the physician or non-physician practitioner providing the direct supervision in Item 31.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

Note: This is a required field; however, the claim can be processed 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 32+ Enter the name, address and ZIP code of the service location for all services other than those furnished in place of service home, 12.

On the CMS-1500 form, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

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

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. The claim must be submitted by the beneficiary on a CMS-1490 form, not a CMS-1500 form.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the six-digit FDA-approved certification number.

Note: When a provider bills for a mammography screening or diagnostic services that have been purchased from a provider location in another contractor jurisdiction, the billing provider must, in addition to reporting its own NPI on paper or electronically submitted Medicare claim (as the billing provider – Item 33), also report its own NPI as the performing provider with the name, address and ZIP code of the performing provider (Items 32 and 32a).

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

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 and the NPI.

 Paper:

32. SERVICE FACILITY LOCATION INFORMATION	
John Smith	
### Any Street	
Anytown, TX #####	
a. NPI	b.

 Electronic:

2310D or 2420C	NM101	77 = Service Location, FA = Facility, LI = Independent Lab, TL = Testing Lab
	NM102	2 = Non-person Entity Type Qualifier
	NM103	Facility or Organization Name
	N301	Address of Service Facility
	N401	City
	N402	State
	N403	ZIP code

Item 32a If required by Medicare claims processing policy, enter the NPI of the service facility.

Note: When a provider bills for a mammography screening or diagnostic services that have been purchased from a provider location in another contractor jurisdiction, the billing provider must, in addition to reporting its own NPI on paper or electronically submitted Medicare claim (as the billing provider – Item 33), also report its own NPI as the performing provider with the name, address and ZIP code of the performing provider (Items 32 and 32a).

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

 Paper:

32. SERVICE FACILITY LOCATION INFORMATION	
a. NPI	b.

 Electronic:

2310D or 2420C	NM108	XX =NPI Qualifier
	NM109	NPI Number
2400	PS101	Purchase Service Provider Identifier
2310C or 2420B	NM101	QB = Purchase Service Provider Qualifier
	NM108	XX = NPI Qualifier
	NM109	NPI Number
2400	REF01	EW = Mammography Certification Qualifier
	REF02	Mammogram Certification Number

Item 32b This field is no longer required by Medicare.

Item 33* Enter the provider of service/supplier's billing name, address, ZIP code and telephone number.

***Note:** CMS requires providers/suppliers to notify Medicare of any changes to their enrollment record within certain time frames. This includes changes to all addresses – practice address, correspondence and special payments address. All providers requesting a change of information must submit the changes on the appropriate Medicare enrollment application (Form CMS-855). Letterhead is not permitted. The changed data must be furnished in the appropriate application section of the CMS-855 form, and the certification statement must contain an original signature and date of an authorized or delegated official currently on record with Medicare. Failure to report a change in a provider's or supplier's information may result in the deactivation of Medicare billing privileges. The claim could be returned if the address in Item 33 does not match the provider file. For more information on the time frames and instructions for updating the enrollment information on a provider/supplier enrollment record, visit the*

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

TrailBlazer Provider Enrollment Web site at <http://www.trailblazerhealth.com/Provider%20Enrollment/Default.aspx?DomainID=1> or call (866) 539-5596 for J4 MAC states. Virginia providers should contact (866) 697-9670.

 Paper:

33. BILLING PROVIDER INFO & PH # (###)### - ####	
John Smith	
### Any Street	
Anytown, TX #####	
a. NPI	b.

 Electronic:

2010AA or 2010AB	NM101	85 = Billing Provider, 87 = Pay-to-Provider
	NM102	1 = Person, 2 = Non-person Entity
	NM103	Provider of Service's/Suppliers Billing Name
	N301	Address
	N401	City
	N402	State
	N403	ZIP code
	PER03	TE = Telephone Number Qualifier
	PER04	Telephone Number

Suppliers billing the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) will use the National Supplier Clearinghouse (NSC) number in this item.

Item 33a* Enter the NPI of the billing provider or group. This is a required field.

Note: Effective March 1, 2008, providers must include an NPI in the primary provider fields (the billing, pay-to-provider and rendering provider fields), Items 24j and 33a. Claims submitted on or after March 1, 2008, without an NPI only or NPI combination in the primary provider fields will be rejected.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

 Paper:

33. BILLING PROVIDER INFO & PH # ()	
a. #####	b.

 Electronic:

2010AA or 2010AB	NM101	85 = Billing Provider, 87 = Pay-to-Provider
	NM108	XX = NPI Qualifier
	NM109	NPI Number

Item 33b This field is no longer required by Medicare.

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

Optical Character Recognition

Although Medicare recommends electronic billing as the optimum method for filing Medicare claims, Optical Character Recognition (OCR) is a technology that permits the recognition and capture of printed data. TrailBlazer uses OCR to scan and lift information printed on the CMS-1500 claim form. OCR claims are subject to the 29-day payment floor. Only electronically filed claims have a reduced payment floor of 13 days.

Through the use of OCR, claims are entered into the processing system more rapidly than paper. In addition to the speed of entry and reduced handling time, the use of OCR reduces administrative costs and minimizes the manual intervention required to correctly process Medicare Part B claims.

Successful OCR begins with the proper submission of claims data. Printed characters must conform to the pre-programmed specifications, relative to character size, and alignment on the CMS-1500 claim form. Only the current CMS-1500 claim form with red dropout ink is acceptable for OCR. These characteristics cannot be copied; therefore, original forms are necessary.

When filing Medicare Part B paper claims, providers are encouraged to type or machine-print all mandated claim fields on the original CMS-1500 claim form.

After the claim information is scanned, it is transmitted to the claims processing system, where it is validated and compared to other data until final processing occurs. To ensure accurate, quick claim processing, the following guidelines should be followed:

OCR User Guidelines – Paper Claims

OCR guidelines for successful completion of the CMS-1500 claim form via paper are as follows:

- Use typewritten characters in 10 or 12 pitch (pica).
- Use standard dot matrix or laser printer fonts – letter quality only:
 - Do not mix fonts on the same form.
 - Do not use italics or script.
- Use uppercase letters for all alpha characters.
- Do not use special characters such as:
 - Dollar signs.
 - Decimals.
 - Dashes.
 - Other symbols or special characters.
- Do not rubber band claims together or staple.
- Enter all information on the same horizontal plane.

MEDICARE PART B

CMS-1500 Claim Form and Unprocessable/Rejected Claims

- Align all information within the designated field.
- Submit only six line items per claim. Do not squeeze two lines of information on one line.
- Extraneous data may not be printed, handwritten or stamped on the form.
- Corrections may be made with white correction tape only. Do not use correction fluid. Cross-outs and information that is written over cause recognition problems.
- Corrections may not be handwritten.
- Avoid old or worn print bands. Print must be dark with completely formed characters. Do not use red ink.
- Do not use hand stamps.
- Do not use highlighter.
- If using carbon forms, please send only the original or top copy.
- Trim forms carefully only at the perforations. Narrower margins cannot be scanned.
- Noticeably thin paper cannot be used (onion skin).
- The claim should be clean, without smudges or discolorations.
- The claim form must measure exactly 8-1/2" x 11".
- Claims that are not folded are easier to scan. Mail claims in large 10" x 13" envelopes.
- Do not submit a zero-charge claim.
- Adjust printers that print slashed zeros to print unslashed zeros.
- You may obtain CMS-1500 claim forms through various vendors, the American Medical Association or the U.S. Government Printing Office.

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

REVISION HISTORY

Date	Revision
June 2007	Updated Item 23 per Change Request (CR) 4374. Added statement asking providers to not submit a Home Health Agency (HHA) or hospice provider number. If they include the number, claims will be returned as unprocessable.
August 2007	<ul style="list-style-type: none">• Updated statement under information provided.• Added information regarding CO16 message and remark codes.• Added link to the Internet-Only Manuals (IOM) and TrailBlazer Web site for additional information regarding unprocessable claims.• Added charts to show items that will reject as unprocessable if not completed correctly.• Added information regarding Item 20 for claims that will reject as unprocessable for diagnostic test subject to purchase price limitations.• Updated claim form examples to show fictitious names, addresses. Numbers have been removed and replaced with a pound sign (#).• Removed the May 23, 2007, deadline for National Provider Identifier (NPI) numbers and replaced with the mandatory date for use of an NPI.• Item 17 – added the UPIN/NPI (when effective).• Item 17a – removed statement that physicians without a UPIN should contact their Medicare contractor.• Item 21 – added information regarding eight diagnosis codes may be used.• Item 32a – added additional information regarding the NPI of the facility.

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

Date	Revision
November 2007	<ul style="list-style-type: none"> • Item 24b – added place of service 16 –Temporary Lodging per CR 5777 effective April 1, 2008. • Added note regarding the Mandatory date of the NPI of all ordering/referring/attending physicians effective May 23, 2008 per CR 5674. • Item 13 – updated information regarding signature in this field per CR 5780. • Items 24j and 33a – per Joint Signature Memorandum (JSM) 08048, added note regarding the mandatory date of the NPI, March 1, 2008, in the primary payer fields.
December 2007	Items 32a and b – updated instructions to read “if required by Medicare” per CR 5749.
February 2008	<ul style="list-style-type: none"> • Unprocessable section – added information for Items 17a, 24g and 33a. • Items 17, 17a and 17b – updated information per CR 5858 to show this information must be reported. • Item 19 – per CR 5858, added information that the NPI must be reported as of May 23, 2008. • Item 24 – per CR 5835, added information regarding the National Drug Code (NDC) number for Medicaid crossovers. • Item 24j – per CR 5858, added note to show that as of May 23, 2008, do not use shaded portion. • Items 32b*, 33b – per CR 5858, added note that these should not be completed as of May 23, 2008. • Item 9d – per CR 5837, added information regarding the new five-digit Medigap code.
March 2008	<ul style="list-style-type: none"> • Updated 17b to show the correct segments for the NPI number. • Updated 24j to show the correct segments for the NPI number.

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CMS-1500 Claim Form and Unprocessable/Rejected Claims

Date	Revision
September 2008	<ul style="list-style-type: none"> • Unprocessable section – deleted PIN reference for Items 33, 17, 17a, 17b and 20. • Updated definition of incomplete or invalid information to remove reference to UPIN and PIN. • Updated all electronic field examples. • Item 17 – removed UPIN information. • Item 17a – updated to explain this field is no longer used. • Item 17b – removed note regarding “when NPI is mandated: • Item 19 – removed “UPIN” reference. • Item 24i – removed. This item is no longer used by Medicare. • Item 24j – deleted information regarding PIN. Removed note regarding the shaded portion. • Item 25 – removed reference to PIN. • Item 32 – removed PIN information. • Item 32b – updated to show this field is no longer required. • Item 32a – removed information about effective date of NPI. • Updated Items 19, 21 and 24j with new paper claim examples. • Updated Item 19 to show hematocrit and hemoglobin information.
November 2008	Per CR 6237 – Updated Items 32 and 32a for the performing provider information in another jurisdiction.
January 2009	Updated Item 21.
February 2009	Updated instructions for Item 11c. Removed unnecessary information for Item 21.
July 2009	<ul style="list-style-type: none"> • Updated Item 17 per CR 6417. • Removed electronic information for Item 19 – Physical and Occupational Therapist. • Updated electronic loops for Item 19 – Purchased Service. • Changed the word “carrier” to “contractor.”
<i>February 2010</i>	<ul style="list-style-type: none"> • <i>Removed Item 17a from the conditional items in the unprocessable chart.</i> • <i>Updated information on the anti-markup limitations for Item 20 per CR 6670.</i> • <i>Item 33 – Added note regarding changes to enrollment records.</i>