# MEDICAL CLAIM SUBMISSIONS

## **New CMS 1500 Claim Form Requirements**





# Learning Objectives

- Understand the new requirements and deadlines
- Understand how to complete the new CMS 1500 claim form (02-12)

### **Medical Submissions: Paper Claim Form**

Partial Implementation – Effective April 1, 2014

Mandatory use of 02-2012 CMS 1500 Form

From this date forward:

- Field 15. Accident Date Must be entered in field 15 using the qualifier "439". Note: The accident date previously was entered in field 14 on the 08/05 form.
- Field 17. Name of Referring Provider or Other Source Until further notice, use qualifier "DN" only. Example: If you are entering an ordering physician, do not use the ordering qualifier; use the "DN" qualifier.
- Field 21. (ICD Indicator)
   Enter a "9" if you are using ICD-9 diagnosis codes. Enter a "0" if you are using ICD-10 diagnosis codes.
   Note: ICD-10 must be used on and after 10/1/2015.
- *Field 21. Diagnosis codes A-L* Now able to enter up to 12 diagnosis codes in this field. Note: The pointer character has changed from numbers to letters.
- Field 24-E. Diagnosis Pointers Must now use the corresponding letter to denote which diagnosis code(s) you are pointing to.

Additional Requirements – Deadline: November 3, 2014 Mandatory use of 02-2012 CMS 1500 Claim Form

From this date forward:

- Field 11b. Other Claim ID (Designated by NUCCU) Enter the "Other Claim ID". When submitting to property and casualty payers, e.g. automobile, homeowner's, or worker's compensation insurers and related entities, use qualifier -Y4 and identifier - Agency Claim Number (Property Casualty Claim Number). Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For worker's compensation or property casualty: If known, enter the claim number assigned by the paper.
- Field 14. Date of Current Illness, Injury, or Pregnancy
   Enter the date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of last menstrual period (LMP). Enter the applicable qualifier:
   431 Onset of Current Symptom or Illness or
   484 Last Menstrual Period.
- Field 17. Name of Referring Provider or Other Source Enter the name (First, Middle Initial, Last) followed by the credentials of the professional who referred/ordered the service/supply. If multiple providers are involved, enter a provider and the applicable qualifier in the following order:
  - DN Referring Provider,
  - DK Ordering Provider,
  - DQ Supervising Provider

Exception: All professional and professional crossover claims require the Ordering Qualifier - DK to be listed 1st when the Provider in Field 17 is one of the following provider types: Independent

Laboratory, Independent Radiology, DME Supplier, Prosthetics/Orthotics, Sole-source eye glass provider.

• Fields 17a. & 17b. (NPI)

Information must support the qualifier information indicated in Field 17. Enter the other ID number of the referring, ordering, or supervising provider. Use the appropriate qualifier to indicate what the ID number represents; enter in field to the immediate right of 17a. Refer to http://nucc.org/ for list of valid qualifiers.

### CMS 1500 02-12 Claim Form

ALTH INSURANCE CLAIM FORM		
ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA
MEDICARE MEDICAID TRICARE CHAMPY	A GROUP FECA OTHER	ta INSURED'S LD. NUMBER (For Program in Item 1)
Medicane#) (Medicant#) (ID#:DoD#) (Member I	De) (ID#) (ID#) (ID#)	
ATIENT'S NAME (Last Name, First Name, Middle Initial)	A PATIENT'S BIHTH DATE SEX	4. INSURED S NAME. (Last Name, First Name, Middle Indial)
ATIENT'S ADDRESS (No. Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADORESS (No., Street)
	Self Spouse Child Other	
Y STATE	A. RESERVED FOR NUCC USE	CITY STATE
CODE TELEPHONE (Include Area Code)		ZP CODE TELEPHONE (Include Area Code)
( )		( )
THER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO.	11 INSURED'S POLICY GROUP OR FECA NUMBER
THER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF BIRTH SEX
	VES NO	MM DD YY M F
IESERVED FOR NUCC USE	6 AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
	YES NO	
ESERVED FOR NUCC USE	C OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	A 10 THEORY AND THE AND A THE OPPOSITE OF SAME
NSURANCE PLAN NAME OR PROGRAM NAME	10d CLAM CODES (Designated by NUCC)	I IS THERE ANOTHER HEALTH BENEFIT PLAN7
READ BACK OF FORM BEFORE COMPLETIN	A & SIGNING THIS FORM	13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to procees the claim Later request payment of povertiment penaltic atthe	relicate of any medical or other information necessary to measify its to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for
bolow.	and the second se	
SKINED	DATE	IRGNED
DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.	OTHER DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
QUAL NAME OF REFERRING PROVIDER OR OTHER SOURCE 12		10 TO
17	NP1	FROM TO YY MM DD YY
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? & CHARGES
		VES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service	rice line below (246) ICD (nd.	22. RESUBMISSION ORIGINAL REF. NO
.L 8 L C L	D L	
F	H L	23. PHIOH AUTHORIZATION NUMBER
	FOURES SERVICES OR SHEPHER ] E	E D H I I
From To PLACEOF (Expl	ain Unusual Circumstances) DIAGNOBIS	DAVE EPEDT ID RENDERING
A DD 11 MAR DD 11 DEMALE EARLY DEMALS	Sua and an	
		NPI
		1091
	1	I I I I HARD ALL AND
		NPI
1 T T T T T T T		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
		NET
		NPI
FEDERAL TAX I.D. NUMBER	ACCOUNT NO. 27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE 29, AMOUNT PAID 30. Revel for NUCC
	YES NO	8
SIGNATURE OF PHYSICIAN OR SUPPLIER 32 SERVICE F INCLUDING DEGREES OR CREDENTIALS	ACIUITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH # ( )
(I cardify that the statements on the reverse apply to this bill and are made a part thansof a		
the second se		
and a second sec		
	h.	a D.

### Field 1a: Insured's ID Number

14. INSURED'S I.D. NU	MBER	(For Program in Item 1)
4. INSURED'S NAME (L	ast Name, First Nar	ne, Middle Initial)
7. INSURED'S ADDRES	SS (No., Street)	
CITY		STATE
ZIP CODE	TELEPH	ONE (Include Area Code)

**Field 1a Other Claim ID** (Designated by NUCCU) – Enter the Vermont Medicaid Unique ID as shown on the beneficiary's Member ID card.

### Field 2: Patient's Name

(Medicare#) (Medic	raid#) (ID#/DoD4)	(Member ID
2. PATIENT'S NAME (LBSt N	lame, First Name, Middle Initia	al)
5. PATIENT'S ADDRESS (N	o., Street)	
CITY		STATE
ZIP CODE	TELEPHONE (Include)	Area Code)
9. OTHER INSURED'S NAM	E (Last Name, First Name, Mi	iddle trittal)
a. OTHER INSURED'S POL	ICY OR GROUP NUMBER	
5. RESERVED FOR NUCC	USE	
C RESERVED FOR NUCCI	USE	
d. INSURANCE PLAN NAMI	E OR PROGRAM NAME	

**Field 2 Patient's Name** – Enter the beneficiary's last and first name.

#### Field 10: Patient's Condition Related To



#### Field 10 Condition Related To -

Check appropriate box to indicate:

- a. Condition is related to employment
- b. Condition is related to auto accident
- c. Condition is related to any other type of accident

Field 11b: Other Claim ID

11. INSURED'S POLICY GROUP OR FECA NUMBER	
	_
b. OTHER CLAIM ID (Designated by NUCC)	
. INSURANCE PLAN NAME OR PROGRAM NAME	-
d, IS THERE ANOTHER HEALTH BENEFIT PLAN?	
YES NO If yes, complete items 9, 9a, and 9d.	
13. INSURED'S OF AUTHORIZED PERSON'S SIGNATURE Lauthorize payment of medical benefits to the undersigned physician or supplier for	
services described below.	
SIGNED	_

# **Field 11b Other Claim ID** (Designated by NUCCU) – Enter the "Other Claim ID".

When submitting to property and casualty payers, e.g. automobile, homeowner's, or worker's compensation insurers and related entities, use qualifier -Y4 and identifier - Agency Claim Number (Property Casualty Claim Number). Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For worker's compensation or property casualty: If known, enter the claim number assigned by the paper. Field 14: Date of Current Illness, Injury, or Pregnancy (LMP)

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

Field 14. Date of Current Illness, Injury or Pregnancy - Enter the date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of last menstrual period (LMP). Enter the applicable qualifier: 431 - Onset of Current Symptom or Illness or 484 - Last Menstrual Period.

Field 15: Other Date

a desired and a second s			-
15. OTHER DATE QUAL.	MM DD	ΥY	

**Field 15. Other Date** - Providers are instructed to put a valid date and valid qualifier in this field. If an Accident Date needs to be reported, the date is to be entered in this field using qualifier "439".

#### Field 17: Name of Referring Provider or Other Source

	A REAL PROPERTY AND A REAL		
17. NAME OF REFERRING	PROVIDER	OR OTHER	SOURCE
TT. THINE OF THE ETHING			

Enter the name (First, Middle Initial, Last) followed by the credentials of the provider who referred/ordered the service or supply. If multiple providers are involved, enter one provider and the applicable qualifier in the following order:

- 1) DN Referring Provider
- 2) DK Ordering Provider
- 3) DQ Supervising Provider

*Exception:* All professional and professional crossover claims require the Ordering Qualifier -DK to be listed 1st when the Provider in Field 17 is one of the following provider types: Independent Laboratory, Independent Radiology, DME Supplier, Prosthetics/Orthotics, Sole-source eye glass provider.

#### Field 17a & 17b NPI

17a.	
17b. NPI	

Information must support the qualifier information indicated in Field 17. Enter the other ID number of the referring, ordering, or supervising provider. Use the appropriate qualifier to indicate what the ID number represents; enter in field to the immediate right of 17a. Refer to http://nucc.org/ for list of valid qualifiers.

21. DIAGNOSIS OR NAT	JRE OF ILLNESS OR INJUR	Y Relate A-L to service line below (24)	E) ICE Ind.
A. L	B.L	c. L	p I.
E. I	F. L	Ø. L	н. 1
	1.1	к. [	L [

#### • Field 21. (ICD Ind.)

An ICD indicator has been added to this field; enter a "9" to indicate that you are using ICD-9 or "0" for ICD-10. <u>Effective 10/1/15</u>, ICD-10 diagnosis codes must be used. This information is required.

#### Field 21. Diagnosis codes A-L

Enter the appropriate ICD-9 or ICD-10 diagnosis code that relates to the service rendered. You are now able to enter up to 12 diagnosis codes in this field.

Field 24

24. A.	DAT From	E(S) O	SERV	To	vv	B. PLACE OF	C.	D. PROCEDURES (Explain Unus CPT/HCPCS	SERVICE	S, OR SUPPLIES Itances)	E DIAGNOSIS POINTED	F E CHARGES	G DAYS OR	H. EPSDT Family Par	L ID OUAL	J RENDERING PROVIDER ID #
TVI IVI	00	-	Print	00			Linna	of moreo 1			[	ap les per rest	- Select	1100	Contrat.	
													1		NPI	
															NPI	
		-									1 1					
_	_	_	_				_							-	(NP)	
											1				NPI	
-				-		1					1					
															NPI	
															NPt	

- **24a. DATE(S) OF SERVICE**\* Enter the date of each service provided. If the From and To dates are the same, the To date is not required.
- 24b. PLACE OF SERVICE\* Enter the appropriate two digit place of service code.
- **24d. PROCEDURE CODE\*** Enter the appropriate procedure code to explain the service rendered.
- 24e. DIAGNOSIS POINTER\* Enter the appropriate diagnosis 'pointer' that relates to the service rendered (A through L) and corresponds to the diagnosis from field locator 21. You may enter up to 4 pointers per detail.
- **24f. CHARGES\*** Enter the usual and customary charge for the service rendered.
- **24g. DAYS OR UNITS**\* Enter the number of days or units of service rendered.
- **24j. ATTENDING PROVIDER**\* Enter attending physician's NPI. Enter the billing provider NPI for independent labs and DME suppliers. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.

### Field 28 Through 33a

25. FEDERAL TAX I.D. NUMBER SSN. EIN	28, PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE	29. AMOUNT PAID	30. Revoltor NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OF CREDENTIALS If cettly that the statements on the reverse apply to this bill and any made a part thereof.)	32 SERVICE FACILITY LOCATIO	N INFORMATION	33. BILLING PROVIDER	NFO & PH # ( )	
SIGNED DATE	а. D.		8.	D.	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

#### 28. Total Charge\* •

Add the charges from field locator 24f for each line and enter the total in this field.

#### 29. Amount Paid\* •

Enter the amount paid by other health insurance coverage (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.

#### 33. Billing Provider\* •

Enter the payee provider name and address (Individual provider format: last name, first name)

33a. Billing Provider's NPI\* • Enter the billing provider's NPI.

					PICA	
MEDICARE MEDICAID TRICARE CHAMPVA	GROUP FECA OTHER	18 INSURED'S I.D. NUM	BER	(	For Program in Item 1)	
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID	#) (ID#) (ID#) (ID#) (ID#)	123456				
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (La	st Name, First	Name, Mit	ddle Initial)	
Last name, First name	6. PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS	(No., Street)			
bis example shows all of the	Self Spouse Child Other					
nandatory fields for a	RESERVED FOR NUCC USE	CITY			STATE	
eneficiary who only has		ZIP CODE	TEL	EPHONE (	Include Area Code)	
/ermont Medicaid				( )		
The VT Medicaid	). IS PATIENT'S CONDITION RELATED TO.	11 INSURED'S POLICY	GROUP OR F	ECA NUM	BER	
beneficiary is the insured	EMPLOYMENT? (Current or Previous)	a INSURED'S DATE OF	BIBTH		SEX	
therefore field / is not a		MM DD	e AV	M	F	
required field	AUTO ACCIDENT? PLACE (State)	5. OTHER CLAIM ID (De	signated by N	UCC)		
Vou do not pood to	YES NO					
• You do not need to		C. INSURANCE PLAN NA	ME OR PRO	GHAM NAM	VE.	
complete the beneficiary	Dd CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
address in field 5 and 7		YES N	) If yes.	complete	tems 9, 9a, and 9d	
• You do not need a	SIGNING THIS FORM. ase of any medical or other information necessary	13 INSURED'S OR AUTH payment of medical be	HORIZED PER enefits to the u	RSON'S SI	GNATURE I authorize d physician or supplier for	
signature on each claim	nyself or to the party who accepts assignment	services described be	low.			
for form nor is it required	DATE	SIGNED 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD MM DD YY				
in field 31	HER DATE MM DD YY					
The signature must be		FROM 18. HOSPITALIZATION D	ATES RELAT	TO TO CU	RRENT SERVICES	
kept on file in your office	NPI	FROM DD	YY	то	MM DD YY	
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?		\$ CHA	RGES	
TUAGNOSIS OR NATURE OF ILL NESS OR INJURY Relate A-L to servi	ce line below (24E)	YES N	0			
I27.2	ICD Ind	CODE	ORIC	GINAL BEF	NO	
E.L		23. PRIOR AUTHORIZAT	NON NUMBE	8		
		E	G H		4	
From To PLACE OF (Expla MM DD YY MM DD YY SERVICE EMG CPT/HCPI	In Unusual Circumstances) DIAGNOSI CS MODIFIER POINTER	S CHARGES	OR Family UNITS Plan	QUAL	RENDERING PROVIDER ID. #	
040114 040114 11 9921	13 A	95.00	1	NPI	1234567890	
TETTI		1		NPI		
				NICI		
				NPI		
				NPI		
				NPI		
			1	NPI		
5, FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	ACCOUNTING 27 ACCEPT ASSIGNMENT?	s 95.00	29. AMC	UNT PAID	30. Rsvd for NUCC Us	
SIGNATURE OF PHYSICIAN OR SUPPLIER     SIGNATURE OF PHYSICIAN OR SUPPLIER     INCLUDING DEGREES OR CREDENTIALS     (I certify that the statements on the roverse     apply to this bill and are made a part thereof.)		Last Name, Street Addre City, State Z	First Na ess ip Code	ame e	)	
IGNED DATE B.	b.	1234567890	b,			
IUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPRO	VED OMB	-0938-1	197 FORM 1500 (02-1	

#### Field 29: Primary Insurance Claim Example

Enter the amount paid by other health insurance coverage, including contractual allowance if applicable (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down, if applicable. Documentation must be attached if the services are not covered by the primary insurer, or if the payment by the primary is \$3.00 or less.

	FECA         OTHER         1a: INSURED'S I.D. NUMBER         (For Program in Item 1)           BXX (LINB3 [ID])         1233456         (For Program in Item 1)           TE         SEX         1233456           M         F         4. INSURED S RAME: (Last Name, First Name, Middle Initial)           HIP TO INSURED         7. INSURED S ADDRESS (No., Street).           Chat         Other           ZUP. CODE         TELEPHONE (Include Area Code)           ()         ()
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE INUCCI 02/12  PICA  I. MEDICARE MEDICAID TRUCARE CHAMPVA CROUP (CDP)	FECA         OTHER         1a: INSURED'S LO. NUMBER         (For Program in Item 1)           BIX         ID80         123456         (For Program in Item 1)           TE         SEX         4. INSURED'S NAME (Last Name, First Name, Midde Initial)           MI         F         7. INSURED S ADDRESS (No., Street).           Child         Other         Citry           ZIP. CODE         TELEPHONE (Include Area Code)           ()         ()
	FECA. BIX (UNIS)         OTHER         1a: INSURED'S 1D. HUMBER         (For Program in Item 1)           (IOP)         123456         (For Program in Item 1)           (IOP)         E         4. INSURED'S HAME (Last Name, First Name, Mode Initial)           40P TO INSURED         7. INSURED S ADDRESS (No., Street).           (Child)         Other         CITY           20P. COCE         TELEPHONE (Include Area Code).           (())         (())
MEDICARE MEDICARD TRICARE CHAMPYA GROUP Medicarder) Medicarder) (DerDobr) Monder Drait Detert's Name (Last Name Frei Name, Middle Indea)     2. PATIENT'S BITTH QA     S PATIENT'S B	FEECUNE         OTHER         1 INSURED'S I.D. NUMBER         (For Program in Item 1)           (707 ***********************************
Last Name, First Name     Contract Name, First Name     Contract Name, First Name     Contract Name, First Name     Contract     Contr	M         F           HIP TO INSURED         7. INSURED S ADDRESS (No., Street).           Crinita         Otheir           ZIP CODE         City           STATE           ZIP CODE         TELEPHONE (Include Area Code)
S. PATIENT'S ADDRESS (No. Street) S. PATIENT'S ADDRESS (No. Street) CITY STATE CITY TELEPHONE (Include Area Code) ( ) S. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Name of Insured A OTHER INSURED'S POLICY ON GROUP NUMBER POLICY POLICY ON GROUP NUMBER CITY	EHP TO INSURED         7. INSURED \$ ADDRESS (No., Street).           Child         Other           20 USE         CITY           ZIP. COCE         TELEPHONE (Include Area Code)           ()         ()
CITY STATE COND ZIP CODE TELEPHONE (Include Area Code) ( ) 8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Name of Insured a OTHER INSURED'S POLICY OR GROUP NUMBER POINTY ICAMP	Citier         STATE           IC USE         City           ZIP. CODE         TELEPHONE (Include Area Code)           ()         ()
ZIP CODE TELEPHONE (Include Area Code) ( ) s OTHER INSURED'S NAME (Last Name, First Name, Middle Indiat) Name of Insured a OTHER INSURED'S POLICY OF GROUP NUMBER POLICY DI IMPORT	ZIP. GODE TELEPHDNE (Include Area Code) ( )
OTHER INSURED'S NAME (Last Name, Fire Name, Middle Insur)     Name of Insured     other insured     OTHER INSURED'S POLICY OF GROUP NUMBER     OTHER INSURED'S POLICY OF GROUP NUMBER	
OTHER INSURED'S POLICY OR GROUP NUMBER	(TION RELATED TO. 11 INSURED'S POLICY GROUP OR FECA NUMBER
	ent of Previous) a INSURED'S DATE OF BITTH SEX
RESERVED FOR NUCC USE 11. AUTO ACCIDENT?	PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
RESERVED FOR NUCC USE     C OTHER ACCEDENT?     VES	C INSURANCE PLAN NAME OR PROGRAM NAME
Insurance Name	Highwated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Lauthorize the release of any madical or of to process the claim. Lalso request payment of government banefits either to myself or to the party who below.	her viformation necessary a accepts assignment 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthonize payment of medical banefits to the undersigned physician or supplier for senices described below
SIGNED DATE	SIGNED
4. DATE OF CURRENT BLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE OUAL OUAL MM	DD YY 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION PROM DD TO TO
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178.	111 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD TO TO TO TO THE TOT
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB <sup>3</sup> \$ CHARGES
1 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	Dind 22 RESUGNISSION ORIGINAL REF NO
	23. PRIOR AUTHORIZATION NUMBER
A.         DATE(S) OF SERVICE         B.         C         D         PROCEDURES. SERVICES.         OF           From         To         PUCEOF         Explain Unusual Originations         Explain Unusual Originations           MM         DO         YY         NM         DO         YY         SERVICE         MOGINE	SUPPLIES E F G H I BUNCHING DAAS EPSCI D RENDERING IER POINTER SCHARGES UNTE New CUAL PROVIDER (D. #
05 25 14 1 99213	A 95 00 1 🖬 123456789
<b>Field C is a required field when Primary</b> Enter the payment plus contractual allowar explanation of benefits (EOB), if the service Include an explanation of the EOB remark deductible or if the payment is \$3.00 or les	<b>Insurance is applicable.</b> nce and enter the sum in field 29. Attach the es are not covered by the primary insurance. when it was applied to the primary insurance s.
, .,	
25, FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO 27	ACCEPT ASSIGNMENT? 28 TOTAL CHARGE 28. A SUNT PAID 30. Revel for NUCC US
SIONATURE OF PHYSICIAN OR SUPPLIER     NOLUDING DEGREES OR CHEDENTIALS     If only that the statematics on the reviews	95 00 75 00 Last Name, First Name
apply to this bill and are made is part thereof (	Street Address City, State Zip Code

### **Medicare Claim Example**

If you do not receive payment from DVHA within 30 days of the Medicare paid date, submit the claim to DXC Technology with a completed *Medicare Attachment Summary Form.* If a service or item is denied by Medicare as non-reimbursable but the service is reimbursable by Vermont Medicaid, submit a CMS 1500 claim for the non-reimbursable service (completed to DVHA specifications) include a copy of the Medicare denial within twelve months of the date of service to DXC Technology.

EALTH INSURANCE O	LAIM FOR	IM						
ROVED BY NATIONAL UNIFORM CLAI	I COMMITTEE (NUI	CC) 02/12						mes.
PICA MEDICADE MEDICAID TI	UCARE	CHAMPVA GB	OUP FECA	OTHER 14	INSURED'S LD. NUMBE	R	(For	Pica Program in item 11
(Medicare#) (Medicard#) (82	W/DoD#)	(Member ID#)	17 BLR LUNG	(104)	123456			
PATIENT'S NAME (Last Name, First Nam	e, Middle Initial)	3. PATIEN	TS BIRTH DATE SE	X 4.1	NSURED'S NAME (Last)	Name, First N	lame, Middle	a Initial)
Last Name, Firs	t Name			F	US DENE ADORECE I	in Theat		
PATIENT'S ADDRESS (No., Street)		6. PATIEN	Secure Child		NSUMED S ADDRESS (	eo , omeed		
TY.		STATE & RESERV	VED FOR NUCC USE	CIT	Ŷ			STATE
CODE TELEPH	ONE (Include Area C	Iode)		ZIP	CODE	TELEF	HONE (Incl	ude Area Code)
VELICE INTO THE PARTY OF MARKET	) Einet Manuel Mathematica	NAME OF THE PAT	ENTR CONDITION BELATE	0.10	INSURED'S POUCY OF		CA NUMBER	8
THEN INSURED S WARE (LESS WORKS,	rate, rearing, weating a	initial in the latent	CHI O CONDITION DECHT			our onre		
THER INSURED'S POLICY OR GROUP	NUMBER	a, EMPLO	MENT? (Current or Previous	a) a.)	NSURED'S DATE OF BI	RTH	10	SEX
			VES X NO		Minist Esta		M	F
ESERVED FOR NUCC USE		B. AUTO A	CCIDENT? PL	ACE (State) b. (	OTHER CLAIM ID (Deeig	nated by NU	CC)	
ESERVED FOR NUCC USE		C OTHER	ACCIDENT?		NSUBANCE PLAN NAM	F OR PROGR	AM NAME	
			VES XNO	-				
NSURANCE PLAN NAME OR PROGRA	MINAME	tod CLAM	CODES (Designated by NU	(CC) d. 1	S THERE ANOTHER HE	ALTH BENER	FIT PLAN?	
					YES NO	If yes: o	omplete iten	ns 9, 9a, and 9d.
READ BACK OF	FORM BEFORE CO	OMPLETING & SIGNING	3 THIS FORM.	13	INSURED'S OR AUTHO	RIZED PERS	ION'S SIGN	ATURE Lauthonize
When Medicare additional infor	e is the mation/f	primary ii fields thai	nsurance, t n what is in	here is clude (	no need on this ex	to co ampl	omple e.	ete any
When Medicare additional information in	e is the   mation/f	primary in fields than	nsurance, t n what is in	here is clude (	no need on this ex	to co ampl	e.	ete any
When Medicare additional information in page of nature of subjects	e is the   mation/f	primary in fields than 175 197	nsurance, t n what is in	here is	on this ex	to cc ampl	e.	ete any
When Medicare additional information in additional class information in plagnosis on nature of Liness [P28.89]	e is the partial to have a second to hav	primary in fields than	nsurance, t n what is in	here is clude ( ?	no need on this ex outside LAP vers no courside LAP	to co ampl	e.	ete any
When Medicare additional information in Additional claw information in Diagnosis on nature of illness P28.89	e is the   mation/f Respirated by NUCC	primary in fields than 175 [187] * * * * * *	nsurance, t n what is in	here is clude ( 20 22 23	no need on this ex outside Lap outside Lap essentiation Recommission	to cc ampl	E.	ete any
When Medicare additional information in additional claw information in pageographic on nature of subjects P28.89	e is the   mation/f resignated by NUCC	primary in fields than 175 term AL to serves the belo c c c c c c c c c c c c c c c c c c c	nsurance, t n what is in	here is clude ( 20 23	no need on this ex move care ourside care ves no recommission Prior authorizatio	to cc ampl	e.	ete any
When Medicare additional inform Additional claim information (C DIAGNOSIS OR NATURE OF ILLNESS P28.89 B L P28.89 B L P28.9 B L	e is the   mation/f www.mation/f www.mation/f con usurer con usure	primary in fields than 175   184 A-L to serves line belo c c c c c c c c c c c c c c c c c c c	nsurance, t n what is in (24E) CD lea p ( RVICES. OR SUPPLIES CREATERING INFILIES MODIFIER	here is clude ( 20 23 0ragross	no need on this ex more take ves no resumission Prior authomizatio	to cc ampl	E. SCHARC	ete any
When Medicare additional inform ADDITIONAL CLAM INFORMATION IC DIAGNOSIS OF NATURE OF ILLNESS P28.89 B P28.89 B P28.89 B P28.9 B P28 B P28.9 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P28 B P2	e is the mation/f mation/f exempted by NUCC OR PLURY Reside	primary in fields than 175 187 AL to serve ine bee c c c c c c c c c c c c c c c c c c	nsurance, t n what is in "(24E) CD Ha H L L RNICES. OR SUPPLIES COUPERR	here is clude ( 20 22 23 Constructions Point tee A	no need on this ex ourside LAP yes no respension price authomization s charges d	to cc ampl onicia in Number onicia in Number in Here in Here i	E CHARC	ete any
When Medicare additional information in additional class information in page 28.89 B P28.89 B P28.89 B Date(s) of Service From (s) of Service 05 14 14 05 14 14	e is the mation/f mation/f wypated by NUCC CR MUURY Rease RACTOR ENG 22 22 22	primary in fields than the last the last of the last of the last o	RVICES OF SUPPLIES CHOPPILES CHOPPILES CHOPPILES CHOPPILES CHOPPILES CHOPPILES CHOPPILES CHOPPILES	here is clude ( 20 22 23 0MGROSS POMPER A A	s no need on this ex moved researcher researcher researcher s changes 27 00 84 00	to cc ampl onicu o	NPI	ete any
When Medicare additional information e additional claw information e P28.89 P28.89 P28.89 Do yy MM D0 yr 05 14 14 05 14 14	e is the mation/f mation/f response to NUCC OR INJURY Results Ract of Struct Exc. 22 22	primary in fields than the price for the left c L	nsurance, t n what is in «(24E) CD Hd P CD Hd H C HVC25. OR SUPPLIES CHORMONIC AND CONTRACT MCDIFIER	here is clude ( 20 22 23 23 24 24 24 24 24 24 24 24 24 24 24 24 24	a no need on this ex outside LAP yes no courside LAP yes no coursi	to cc ampl onical in NUMBER 1 1	to     s chance     to     s chance     to     s chance     to     to	ete any
When Medicare additional information e additional claw information e page 28.89 P28.89 B Date(s) of Service From y MM CD y 05 14 14	e is the mation/f mation/f receptuted by NUCC OR MAURY Reserved RACE of EMG 22 22	primary in fields than 1% 1% 1% AL 10 serves live belo 6 CPTACTOURES SE CPTACTOURS SE CPTACTOURS SE CPTACTOURS SE SECONDARY SE 99213 31575	r (24E) CD led (24E) CD led (24E) CD led (24E) CD led (25) (25)	here is clude ( 20 22 23 COMACHOSISS POINTER A A	s no need on this ex more taken yes no respension respe	to cc ampl onicu in NUMBER	I S CHARCO	PROVIDER ID. #
When Medicare additional information in ADDITIONAL CLAW INFORMATION IN P28.89 P28.99 P	e is the mation/f	primary in fields than the law of the law c L law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law	A CARE CO INSU A CARE CO INSU	here is clude ( 20 20 20 20 20 20 20 20 20 20 20 20 20	с no need on this ex тиои очтысе саят чез по терерализато вереализато 27 00 84 00	to cc ampl orica w NUMBER	Imple           Imple           S CHARC           S CHARC           NRI           Imple           NPI           NPI           NPI           NPI           NPI           NPI           NPI	ete any
When Medicare additional information e additional class information e P28.89 P28.89 B D D Y MM DD Y 05 14 14 05 14 14	e is the mation/f	primary in fields than the price for below c L c L c C c C c C c C c C c C c C c C c C c C	A CARE CO INS A CARE	here is clude ( 20 20 20 20 20 20 20 20 20 20 20 20 20	A no need on this ex outside LAP VITSIDE LAP COUTSIDE LAP	to cc ampl onion in NUMBER 1 1	Imple           Imple           S CHARC           S CHARC           Imple           Imp	ete any
When Medicare additional information in additional claw information in padmoses on nature of illness P28.89	e is the mation/f mat	primary in fields than the last the last c L c L c L c L c L c L c L c L c L c L	A COLOR AND A COLO	here is clude ( 20 20 20 20 20 20 20 20 20 20 20 20 20	no need on this ex (1909) (19	to cc ampl	I         I           S CHARC         I           NRI         I           NPI         I	ete any
When Medicare additional inform ADDITIONAL CLAW INFORMATION IC DIAGNOSIES OF NATURE OF ILLNESS P28.89 P DO YY NM DD Y 05 14 14 05 14 14 05 14 14	e is the mation/f mation/f mation/f mation/f mation/f mation/f eegvated by NUCC R R R R R R R R R R R R R R R R R R	primary in fields than 1% 1% 1% 6AL to service line before 6 L 6 Productories as 10 PROCEDURES 88 10 PROCEDURES 88 10 PROCEDURES 88 10 PROCEDURES 88 10 PROCEDURES 88 10 PROCEDURES 10 PROCESSION 10 PROCESION 10 PROCESSION 10 PR	A COLOR AND A COLO	here is iclude ( 20 22 23 24 24 24 24 24 24 24 24 24 24 24 24 24	с no need on this ex ////////////////////////////////////	to cc ampl orica w NUMBER 1 1 1 29 AMOU 8	I         I           S CHARC         S CHARC           NAL REF N         NPI           NPI         I           N	ete any
When Medicare additional inform	e is the mation/f mation/f exegnated by NUCC OR INJURY Relate PLCC C 22 22 22 22 22 22 22 22 22 22 22 22 22	Primary in fields than the last the last of the server line before the last of the server line before the last of the last of	ATION REPORTATION	here is clude ( 20 22 23 CALCHOSES POINTER A A A A A A A A A A A A A A A A A A A	no need on this ex mice ourse Lan research research research 27 00 84 00 84 00	to cc ampl	Imple           scharc           scharc           NAL REF N           NPI	ete any

Please complete and attach the Medicare Attachment Summary Form to the CMS 1500 Claim Form, this replaces the need to submit a copy of the Medicare EOB.

The Medicare Summary Attachment Form is designed to assist providers submitting Medicare deductible and/or co-insurance claims. Six lines are provided to correlate

to the six claim lines/details contained on the CMS 1500 Claim Form. The Medicare Summary Attachment Form must be completed and attached to all CMS 1500

claims for Medicare deductible and/or co-insurance.

- Please DO NOT staple or paper clip this form to your claims
- Billing provider and Recipient information section must be completed as indicated on the claim

**Other Insurance** - Check yes or no. If you are checking yes also enter the payment in the amount field. If there is no payment, please attach the other insurance EOB.

**Medicare Paid Date** – Enter Medicare EOMB date from the Medicare EOB. If you have more than one EOB for the same claim, enter the oldest Medicare EOMB Date.

**Total Medicare Paid Amount** - Enter the SUM of the Medicare paid amounts from the Medicare EOB for the details that apply to the crossover claim.

Medicare Deductible – Enter the DEDUCTIBLE amount for each applicable detail.

Medicare Co-Insurance – Enter the CO-INSURANCE amount for each applicable detail.

**Medicare Paid Amount** – Enter the Medicare Paid Amount for each applicable detail. If you have more than one payment for the same claim, combine the payments.

**Medicare ICN** – please enter the ICN for the applicable detail from the Medicare EOB. If you have more than one EOB for the same claim, enter the ICN from the oldest Medicare EOB.

**Mental Health Claims** - Add the co-insurance amount and the PR-122 line amount together; enter the sum in the Co-insurance field.

**Medicare Part C** – please add co-pay to the co-insurance amount; enter the sum in the Co-insurance field.

Please note: Medicare Part C - Add the co-pay to the co-insurance and enter the sum in field 4c.

#### CMS 1500 MEDICARE ATTACHMENT SUMMARY

Please use this form in lieu of attaching the Medicare Explanation of Benefits (EOB) when billing Vermont Medicaid for Medicare Deductible and/or Coinsurance.

All the fields on this form must be completed in order to process your claim in a timely manner. If any of the fields are not completed, the claim and attachments will be returned to you for completion. Do not modify this form; enter information in the designated field.

This attachment MUST NOT be used when submitting claims electronically.

Indicate Part C Carrier:

3 4 5

(If applicable, please add co-pay to the co-insurance amount and enter the sum in the Co-Insurance Amount Field)

Billing Provider Name: Last Name, First Name

(must match the provider name, as it appears, in form loc. 33 on your CMS1500 claim form) Beneficiary (Patient) Name. Last Name, First Name

(must match the beneficiary (patient) name, as it appears, in form loc. 2 on your CMS1500 claim form)

				-			
1. Other In	nsurance		a. Yes	b	. No		
(Checi	k One)				$\checkmark$		
			c. Amount				
2. Medica	re Paid Date		06/30/2014				
3. Total M	edicare Paid Amount 80.57						
4a. Detail # (Do not edit <mark>)</mark>	b. Medicare Deductible		c. Medicare d. Med Co-insurance Paid A		icare mount	e. Medicare IO	
1			4.93 19.7		19.71		39123410352
2			15.21		60.8	6	39123410352
		T					

6 Please verify that the claim detail number information on this attachment corresponds to the claim detail number on the CMS 1500. Inaccurate information will result in claims processing errors.

**The billing provider must indicate their last name and then their first name.** Complete field 1a if there is other insurance like UHC or AARP. Their payment would be entered in field 1c. If there is no other insurance other than Medicare, complete field 1b. Enter the Medicare paid date in field 2 and the Medicare payment in field 3. Complete 4a, b, c, d and e for each detail as shown.

'N

30 30

### **Miscellaneous CMS 1500 Billing Instructions**

#### **Multiple Page Claims**

When billing a multiple page claim, you must indicate "page x of y" in Box 19, "Local Use" of the CMS-1500 claim form. To indicate the conclusion of the entire claim, field 28 of the last page of the claim must also include the total billed amount. Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) & 3 of 3 (3rd page of claim).

#### **Field Locators**

All information on the CMS 1500 Claim Form should be typed or legibly printed. Only the 02-12 version of this form is accepted for processing. The field locators listed below are used by DXC when processing Vermont Medicaid claims. The field locators designated by an asterisk (\*) are mandatory; other field locators are required when applicable. The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

### **Common Mistakes**

- Alignment text entered on the claim is offset from the boxes on the claim form
- Mandatory Fields are not completed
- Individual Provider Name (Field Locator 33) is incorrectly formatted. This should be Last Name, First Name to be considered correctly formatted
- Insured's ID should <u>not</u> be the social security number, it should be the beneficiary's Vermont Medicaid Unique ID (UID) Number

### **Frequently Asked Questions**

#### Q. What is a diagnosis pointer?

A. The diagnosis pointer(s) go in field 24E and they relate back to the diagnoses indicated in field 21.

#### Q. Does the provider have to sign the claim form?

A. The provider does not have to sign the claim form.

#### Q. What is a taxonomy code?

A. The taxonomy indicate the specialty of the provider. You would have indicated this when you applied for your NPI.

#### Q. Where do we get the diagnosis codes?

A. You get the diagnosis codes from the ICD-10 for Diagnosis Codes manual or go www.ICD10data.com

#### Q. What is a CPT code or HCPCS?

A. The CPT code or HCPCS is the code that describes the service you have rendered. You must use a CPT manual to research what codes to bill.

#### Q. Why are claims returned that have staples?

A. Staples cause issues with our optical character reader. Even if they are removed, the holes they create can cause the optical scanner to jam.

#### Q. Where do we find CMS 1500 claim forms?

A. You can get CMS 1500 claims forms at an office supply store.

### Resources

- Vermont Medicaid Website <u>http://www.vtmedicaid.com/#/home</u>
- Green Mountain Care Provider Manual, Supplements and Other Informational Resources
  - o <u>http://www.vtmedicaid.com/#/manuals</u>
  - <u>http://www.vtmedicaid.com/#/resources</u>
- Claims Related Forms <u>http://www.vtmedicaid.com/#/forms</u>
- Vermont Medicaid Banner <u>http://www.vtmedicaid.com/#/bannerMain</u>
- Department of Vermont Health Access Advisory <u>http://www.vtmedicaid.com/#/advisory</u>
- DXC Technology Provider Electronic Solutions (PES) Free Billing Software <u>http://www.vtmedicaid.com/#/pes</u>
- CPT Code Book and HCPCS Code Manual available for purchase online and at local book retailers
- ICD 10 for Diagnosis Code Manual available for purchase online and at local book retailers