MEDICAL CLAIM SUBMISSIONS

New CMS 1500 Claim Form Requirements

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

DXC.technology

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

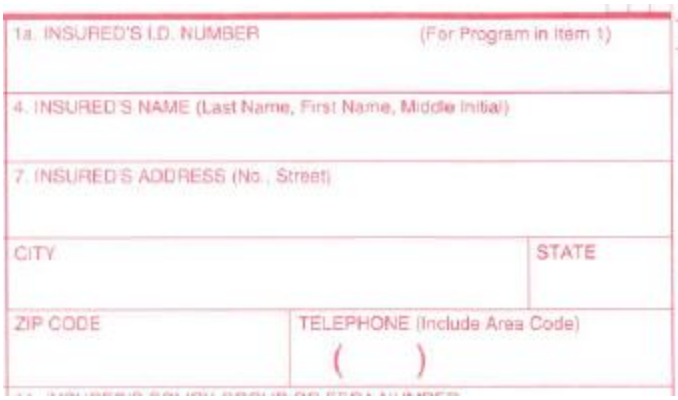
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Field 1a: Insured's ID Number


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

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

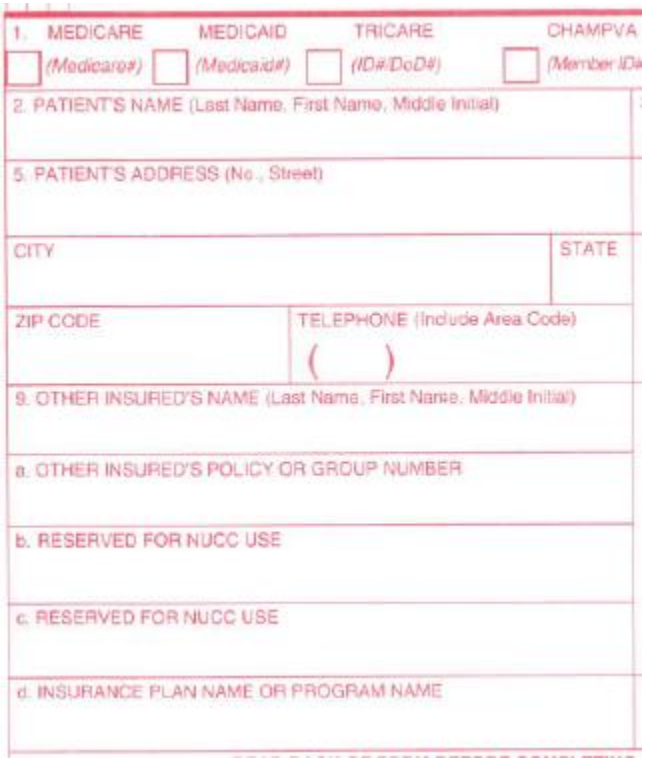
7. INSURED'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (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


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#

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

5. PATIENT'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

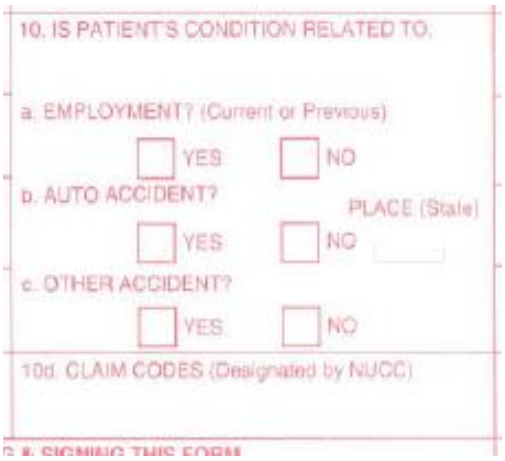
b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

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

Field 10: Patient's Condition Related To


10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

YES NO

b. AUTO ACCIDENT? PLACE (State)

YES NO

c. OTHER ACCIDENT?

YES NO

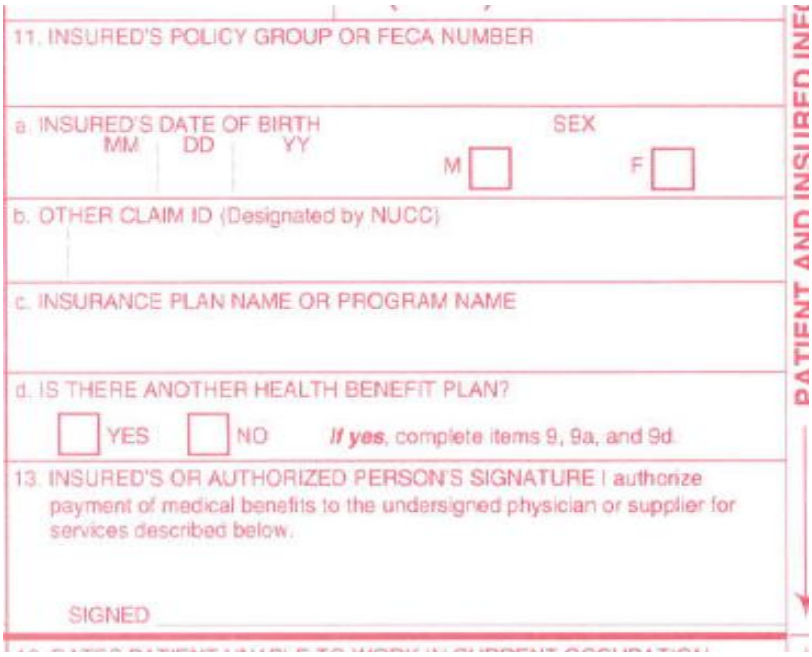
10d. CLAIM CODES (Designated by NUCC)

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

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. 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 OR AUTHORIZED PERSON'S SIGNATURE I authorize 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)
MM DD YY 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

15. OTHER DATE
QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

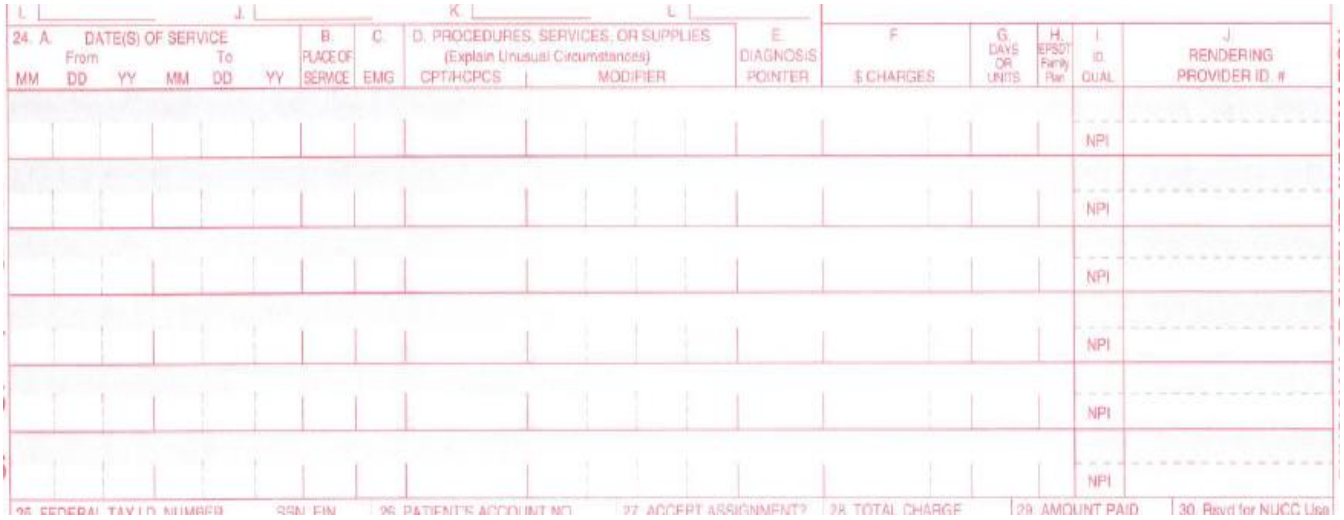
17a.
17b. NPI

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.

Field 21: Place of Treatment

- **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. Effective 10/1/15, 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



- **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	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a.	b.	a.	b.	

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- **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.

Example of All Mandatory Fields

This example shows all of the mandatory fields for a beneficiary who only has Vermont Medicaid.

- **The VT Medicaid beneficiary is the insured; therefore, field 4 is not a required field**
- **You do not need to complete the beneficiary address in field 5 and 7**
- **You do not need a signature on each claim for form nor is it required in field 31**
- **The signature must be kept on file in your office**

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Last name, First name

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

AUTO ACCIDENT? YES NO X PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. CLAIM CODES (Designated by NUCC)

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

SIGNING THIS FORM. ase of any medical or other information necessary myself or to the party who accepts assignment

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

HER DATE MM DD YY

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

NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. I27.2 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
040114	040114	11		99213		A	95.00	1		NPI	1234567890
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 95.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )
Last Name, First Name
Street Address
City, State Zip Code

a. 1234567890 b. b.

CARRIER

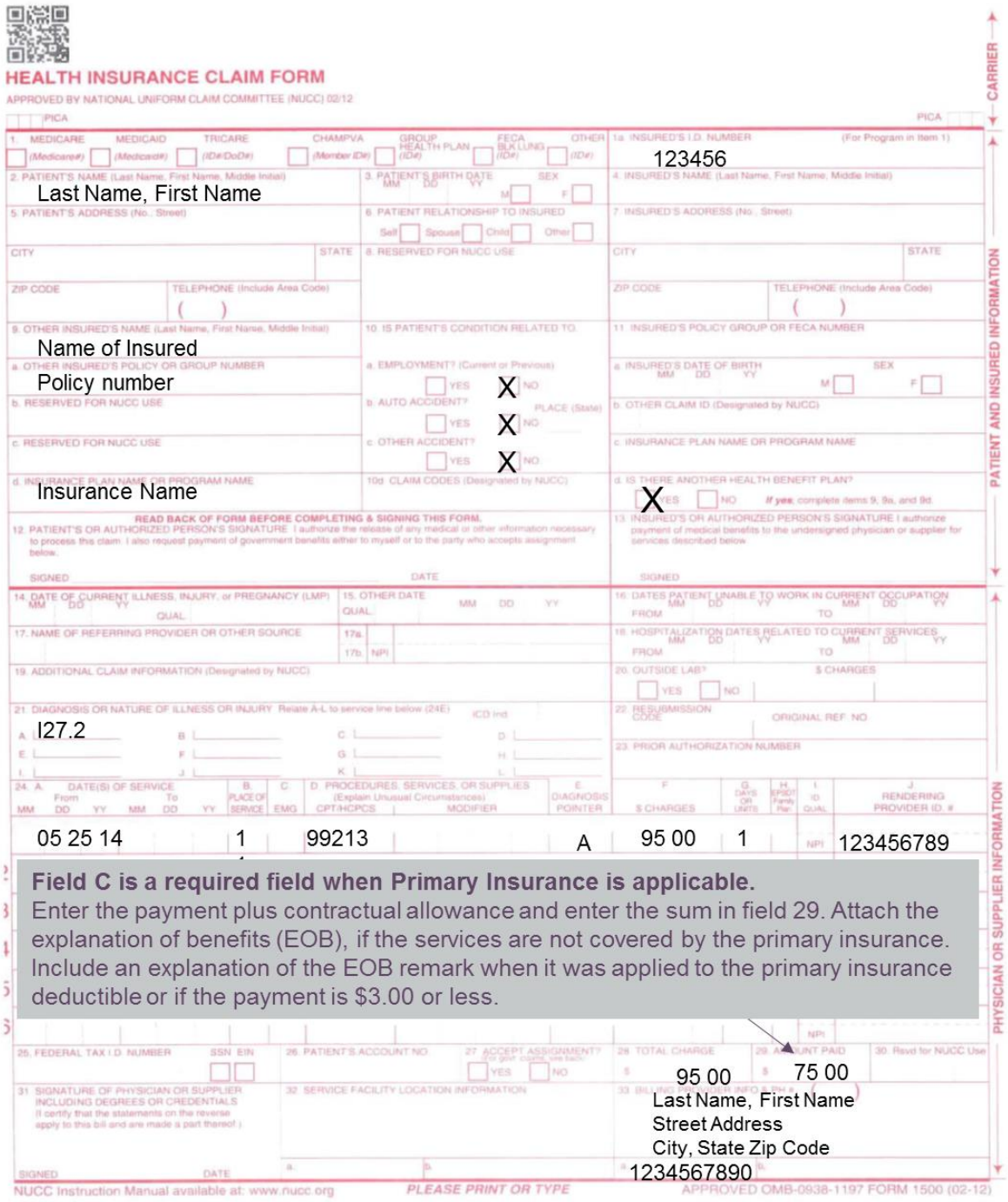
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

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.



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.

HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

When Medicare is the primary insurance, there is no need to complete any additional information/fields than what is include on this example.

17. NPI

FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. P28.89 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
05 14 14		22		99213	25	A	27 00	1		NPI	
05 14 14		22		31575		A	84 00	1		NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 111 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

Last Name, First Name
Street Address
City, State, Zip code

SIGNED DATE a. b. a. b.

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Instructions for Completing the CMS 1500 Medicaid Summary Attachment Form

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.

Example of CMS 1500 Medicaid Attachment Summary Form

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: _____

(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 Insurance (Check One)	a. Yes	b. No
	☐	☑
	c. Amount	
2. Medicare Paid Date	06/30/2014	
3. Total Medicare Paid Amount	80.57	

4a. Detail # (Do not edit)	b. Medicare Deductible	c. Medicare Co-insurance	d. Medicare Paid Amount	e. Medicare ICN
1		4.93	19.71	3912341035230
2		15.21	60.86	3912341035230
3				
4				
5				
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.*

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 – http://www.vtmedicaid.com/#/home
- Green Mountain Care Provider Manual, Supplements and Other Informational Resources
  - http://www.vtmedicaid.com/#/manuals
  - http://www.vtmedicaid.com/#/resources
- Claims Related Forms – http://www.vtmedicaid.com/#/forms
- Vermont Medicaid Banner – http://www.vtmedicaid.com/#/bannerMain
- Department of Vermont Health Access Advisory – http://www.vtmedicaid.com/#/advisory
- DXC Technology Provider Electronic Solutions (PES) Free Billing Software – http://www.vtmedicaid.com/#/pes
- 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