

Claim Form Billing Instructions

CMS – 1500 Claim Form

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or former)	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
SIGNED DATE		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
		b. EMPLOYER'S NAME OR SCHOOL NAME	
		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # if yes, return to and complete item 11	
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
		SIGNED	

Item number	Required Field?	Description and Instructions.
1	Optional	Indicate the type of health insurance for which the claim is being submitted.
1a	Required	Insured's ID Number: Enter the patient's Medicaid ID number in this Item. Medicaid IDs are 9, 10, or 14 digits. Please note: A Medicaid client is always the insured person; the patient and the insured are the same person.
2	Required	Patient's Name: Enter Last Name, First Name, and Middle Initial (if applicable.) Please Note: The name should match the patient's name on the Web Portal.
3	Required	Patient's Birth Date and Sex: Enter the patient's date of birth in MMDDCCYY format. Check the appropriate box indicating the patient's gender.
4	N/A	Insured's Name: Since the Medicaid patient is the insured, it is not necessary to enter the information in this field.
5	Optional	Patient's Address: This information is not used in claims processing, but can be entered if desired.
6	N/A	Patient Relationship to Insured: Since a Medicaid client is both the patient and the insured the relationship is always self , but it is not necessary to complete this item.
7	N/A	Insured's Address: Since the patient is the insured, it is not necessary to enter this information.
8	Optional	Patient status: Check applicable boxes
9a-d	Situational	Other Insured's Information: Information is required in boxes 9a-d ONLY IF box 11d is checked because the patient has a third party health insurance plan. Do not fill in Items 9a-9d if the client has Medicare (including Medicare Advantage Plans) or is served by the Indian Health Service (IHS.) If a third party health insurance policy exists, enter the appropriate information in this field. DO NOT enter terms such as "Medicaid", "ACS", "IHS", "SALUD!", or other words that are not related to the third party payer. Entering these kinds of terms can cause a delay in processing and/or claim denials.
10a-c	Required	Is Patient Condition Related to: check boxes as appropriate. Only one box on each line can be checked.
10d	Not Used	Reserved for Local Use: Leave this box blank.
11a-c	N/A	Insured's Information: Since the patient is the insured, it is not necessary to enter this information in boxes 11a-11c.
11d	Situational	Is There Another Health Benefit Plan?: Check yes box ONLY when the patient has a third party health insurance plan that is the primary payer on the claim. EXCLUDING Medicare, Medicare Advantage Plans, IHS, SALUD!, ect. These are not third party payers for New Mexico Medicaid clients.
12	Not Required	Patient's or Authorized Person's Signature: Not required
13	Not Required	Insured's or Authorized Person's Signature: Not required

14. DATE OF CURRENT ILLNESS (First sympt. INJURY (Accident) OR PREGNANCY(LMP)) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. _____ 2. _____ 3. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER

Item number	Required Field?	Description and Instructions.
14	Optional	Date of Current Illness, Injury, or Pregnancy: Enter date in MMDDCCYY format.
15	Optional	If Patient Has Had Same or Similar Illness: Enter date in MMDDCCYY format. Please Note: a previous pregnancy is not considered a same or similar illness.
16	Optional	Dates Patient Unable to Work in Current Occupation: Enter dates in MMDDCCYY format.
17	Situational	Name of Referring Provider or Other Source: The New Mexico Medicaid Program requires referring Porvider information for certain services. Enter the referring provider's name here using first name, last name format.
17a	Optional	Referring Physician Other ID Number: If a referring provider name is entered in Item 17 the provider's New Mexico ID number can be entered here along with the qualifier 1D if desired.
17B	Situational	Referring Physician NPI: If a referring providers name is present in item 17, the referring provider's NPI is required and MUST BE present in field 17b. Please Note: The referring physician must be a registered New Mexico Medicaid provider.
18	Situational	Hospitalization Dates Related to Current Services: The hospitalization dates entered in this field are related to an inpatient stay. The "from date" entered is the admission date and the "to date" is the discharge date. Leave the "to" date blank if patient is not discharged. Date format is MMDDCCYY format.
19	N/A	Reserved for local use: Leave this field blank.
20	N/A	Outside Lab? \$Charges: Data in this field is not used or captured by NM Medicaid.
21	Required	Diagnosis or Nature of Illness or Injury: The NM Medicaid fee-for-service program requires at least one valid ICD-9 CM diagnosis code on all claims except for claims submitted for services covered under the HCBS waiver program, and non-emergency transportation services. A total of 8 diagnosis codes can be accepted. They can be entered in the 4 designated places in Item 21 or directly in box 24E if more than 4 need to be entered. For more on diagnosis codes, see information about Item 24E.
22	N/A	For Medicaid claims, enter the 17-digit Medicaid assigned TCN for a previous submitted claim, which was received by ACS within the initial filing limit, in the Original Ref. No. location.
23	Situational	Prior Authorization Number: A valid prior authorization number must be present when NM Medicaid fee-for-service program policy requires prior authorization for a service billed on the claim. Only one prior authorization can be submitted per claim. Prior authorizations can be 10 or 11 digits in length.

24	A DATE(S) OF SERVICE				B PLACE OF SERVICE	C EMG OPT-INDICATOR	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS OR UNITS	H QUALIFIER	I QUAL	J RENDERING PROVIDER ID #	PHYSICIAN OR SUPPLIER INFORMATION
	From	To	MM	DD			YY	MM							
1	24A				24B	24C	24D		24E	24F	24G	24H	24I	24J	
2															
3															
4															
5															
6															

Item number	Required Field?	Description and Instructions.
24a-j	Introduction	Section 24: This section is comprised of six service lines. The six service lines have been divided horizontally. The top area of the six service lines is shaded and is intended for reporting certain “supplemental” information, but unless otherwise instructed, do not enter information in the shaded areas of the service line. A valid claim must have at least one completed service line. The instructions for each field on the service line (24A-J) apply to all six lines.
24a	Required	Dates of Service: A “from” date of service (DOS) must be entered. If a “to” DOS is not entered, the “from” DOS will be used as the “to” DOS. Enter dates in MMDDCCYY format. NDC - Beginning at the left edge of the shaded area of field 24A, enter the 2-digit qualifier “N4” immediately followed by the 11-digit NDC. For example, the entry for the NDC code 00054352763 would be: N400054352763.
24b	Required	Place of Service: A valid 2-digit place of service is required.
24c	N/A	Emergency Indicator: Not required and not used in claims processing.
24d	Required	Procedures, Services, or Supplies: Part 1 - CPT/HCPCS: Enter a 5-digit CPT or HCPCS code that identifies the service performed. The code must be valid and in effect on the line’s DOS. Part 2- Modifier: Enter up to four, 2-digit modifiers in the individual boxes. Modifiers entered must be valid modifiers.
24e	Required	Diagnosis Pointer: Information in this field is required for all claims where a valid diagnosis code is required (see instructions for Item 21.) The NM Medicaid fee-for-service program accepts the diagnosis “pointer” or an actual diagnosis code in this field. The pointer is a single numeric digit that refers to the diagnoses entered in Item 21 in the fields marked “1”, “2”, “3” and/or “4”. If a diagnosis pointer is entered in box 24E, it must be 1, 2, 3 or 4, and a valid diagnosis code is required in the corresponding field in Item 21. A valid diagnosis code can also be entered directly in box 24E.
24f	Required	\$ Charges: Enter billed amount for the service line. Enter dollar amount to the left of dashed line and cents to the right of the dashed line. For-profit providers must include gross receipts tax in the total charges entered on each service line. Do not submit a separate service line for tax. Service lines with no charges will be denied.
24g	Required	Days or Units: Enter amount of units of service being billed as appropriate for the procedure code being billed. Enter a numeric value.

	24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. S. CHARGES	G. DAYS OR UNITS	H. EPSTDT INDICATOR	I. ID QUAL	J. RENDERING PROVIDER ID #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	YY										
1													
2													
3													
4													
5													
6													

Item number	Required Field?	Description and Instructions.
24h	Optional	EPSTDT and Family Planning Indicator: Enter Y or N in the shaded area to indicate if services are EPSTDT related. Enter Y or N in the non-shaded area to indicate if services are family planning related.
24i	Situational	ID Qualifier: The 2-character qualifier code indicates what type of information is entered in the shaded area of box 24J. Enter "ZZ" if the rendering provider's taxonomy code is entered in the shaded area of box 24J. Enter "1D" if the rendering provider's NM Medicaid ID is entered in the shaded area of box 24J. If nothing is entered in the shaded area of box 24J, leave 24i blank.
24j	Situational	Rendering Provider ID Number: Enter rendering provider information when required by Medicaid policy. The NPI must be present when the rendering provider is a health care provider. The provider's NPI is entered in the non-shaded area marked "NPI". Entering the rendering provider's taxonomy is optional but recommended. If taxonomy is entered, it is placed in the shaded portion of box 24J. If the rendering provider is an atypical provider (not a health care provider) and therefore does not have an NPI, enter the rendering provider's NM Medicaid ID number in the shaded area. Leave the unshaded area blank. Be sure the qualifiers entered in box 24i are correct. Please see instructions for 24i for critical information about qualifiers.

25. FEDERAL TAX ID NUMBER 25	BSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 26	27. ACCEPT ASSIGNMENT? FOR GOVT. EMPLOYEES, 9901000 <input type="checkbox"/> YES <input type="checkbox"/> NO 27	28. TOTAL CHARGE \$ 28	29. AMOUNT PAID \$ 29	30. BALANCE DUE \$ 30
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof.) 31		32. SERVICE FACILITY LOCATION INFORMATION 32		33. BILLING PROVIDER INFO & PH # 33		
SIGNED _____ DATE _____		a. 32a NPI		b. 33a NPI		
		b. 32b		b. 33b		

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Item number	Required Field?	Description and Instructions.
25	Optional	Federal Tax ID Number: Enter billing provider's tax ID number here. Check indicator box to identify what type of ID number it is.
26	Optional	Patients' Account Number: Enter the patient's account number here.
27	Required	Accept Assignment: Provider must accept assignment. Check indicator as such.
28	Required	Total Charge: Enter total of all service line charges. The total charge amount MUST equal the sum of all service line charges.
29	Situational	Amount Paid: Enter the amount paid on this claim by a third party payer with the following exceptions: Do not enter previous payments Medicare has made on this claim; do not enter previous payments Medicaid has made on this claim. If billing for a copayment from a commercial payer or from a Medicare Advantage claim, enter the difference between the total billed and the copayment amount you want to collect. The copayment amount is then entered in Item 30. Write "HMO copayment due" or "Medicare Replacement Plan copayment due" on the claim where it can be easily seen. To bill for a coinsurance and/or deductible from a commercial plan, enter the total payment from the payer in this field. To bill for a copayment, coinsurance and/or a deductible from a commercial plan, bill for whichever is less, the copayment or the coinsurance plus any deductible amount, if applicable.
30	Situational	Balance Due: Always enter the amount due in Item 30 when a previous payment amount has been entered in Item 29. The amount entered in Item 30 must equal the total charges entered in Item 28 less the amount entered in Item 29. If a previous payment amount has not been entered in Item 29, then entering an amount in Item 30 is optional. If an amount is entered, it must be the same as the total charges entered in Item 28.
31	Required	Signature of Physician or Supplier: A signature and date are required. The signature can be an original signature, a stamped signature, a typewritten signature, or a printed signature, but it MUST be the name of a person. It cannot be "signature on file" or the name of a facility. Enter date in MMDDCCYY format.
32	Situational	Service Facility Location Information: This field is required if the place of service on any service line equals 21, 22, 23, 31, 32, 51 or 54. Enter the service facility name and address. The service facility can also be entered even if it is not required.
32a	Situational	Service Facility NPI: The service facility's NPI is required if the place of service on any service line equals 21, 22, 23, 31, 32, 51 or 54.
32b	N/A	Other Identifier: Leave blank
33	Required	Billing Provider Info and Phone #: Enter the billing (pay-to) provider's name, address and phone number (optional) in this field. If the billing provider has multiple locations in order to pay different gross receipts tax rates, and has a single NPI, enter the location's address and the location's zip code here.
33a	Situational	Billing Provider's NPI: Enter the billing (pay-to) provider's NPI here if the billing provider is a health care provider. All health care providers must bill with their NPI. Providers who provide both health care and atypical services need an NPI to bill for health care services and can also bill atypical services using the NPI. Waiver providers billing atypical services with their NPI must use the taxonomy code 174400000X in field 33b (see below) so the claim can be identified as a waiver claim.
33b	Situational	Other ID Number: The billing provider's taxonomy code is not required if the billing provider's NPI number is present in Item 33a BUT it is recommended that it be entered. Enter qualifier "ZZ" and the billing provider's 10-digit taxonomy code. Do not enter a space between the "ZZ" qualifier and the taxonomy code. For example: ZZ1234567890. If an NPI is not entered in field 33a, enter qualifier "1D" and the billing provider's NM Medicaid ID number. The Medicaid ID number must be 8 digits. If the provider's Medicaid ID number is 5 digits, put 3 zeroes in front. For example, the provider's Medicaid ID number is A1111. In field 33b, it would be entered as 1D000A1111. If the Medicaid ID number is 12345678, it would be entered in field 33b as 1D12345678. Remember that only atypical (non-health care providers) should bill with a NM Medicaid provider ID number. All health care providers must bill with their NPI. Providers who provide both health care and atypical services need an NPI to bill for health care services and can also bill the atypical services using the NPI. Waiver providers billing atypical services with their NPI must use the taxonomy code 174400000X to identify it as a waiver service.