6.5.3 CMS-1500 Blank Paper Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID 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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								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. BALANCE DUE $

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

EXHIBIT 16
CFHP_1326GEN_0121

6.5.5 CMS-1500 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the CMS-1500 paper claim form. Block numbers *not* referenced in the table may be left blank. They are *not* required for claim processing by TMHP.

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit patient number from the Medicaid identification form. For other property & casualty claims: Enter the Federal Tax ID or SSN of the insured person or entity.
2	Patient's name	Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's gender by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the client's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information such as: • If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	Is patient's condition related to: a. Employment (current or previous)? b. Auto accident? c. Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. • For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.

Block No.	Description	Guidelines
14	Date of current	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.
17 17b	Name of referring physician or other source	Enter the complete name (block 17) and the NPI (block 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider. Refer to specific sections for requirements. in the following situations: **The attending physician for:** • Clinical pathology consultations to hospital inpatients or outpatients • Services provided to a client in a nursing facility (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) **The referring physician for:** • Services provided to managed care clients (must be the client's primary care provider). ***Note:*** *If there is not a referral from the primary care provider, a prior authorization number (PAN) must be on the claim.* • Consultation services • CCP services • Radiology services. • Radiation therapy services. **The ordering physician for:** • Laboratory and radiology services • Speech-language therapy • Physical therapy • Occupational therapy • In-home TPN services The designated provider for nonemergency services provided to limited clients on referral. The performing provider (surgeon) for freestanding ASCs.

Block No.	Description	Guidelines
19	Reserved for local use	**Transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other client's complete name and Medicaid number. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
20	Outside lab	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32.
21	Diagnosis or nature of illness or injury	Enter up to four ICD-10-CM diagnosis codes to the highest level of specificity available.
23	Prior authorization number	Enter the PAN issued by TMHP. For Workers Compensation and other property and casualty claims, this is required when prior authorization, referral, concurrent review, or voluntary certification was received.
24	(Various)	General notes for blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. **NDC** In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. **Example:** N400409231231 ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24b	Place of service	Select the appropriate POS code for each service from the table under subsection 6.3.1.1, "* Place of Service (POS) Coding" in this section.
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. ***Refer to:*** Subsection 5.3.4, "THSteps Medical Checkups" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Block No.	Description	Guidelines
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **NDC** **Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24e	Diagnosis pointer	Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** *The maximum number of units per detail is 9,999.* **NDC** **Optional:** In the shaded area, enter the NDC unit of measurement code. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24j	Rendering provider ID # (performing)	Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the taxonomy in the shaded area of the field.[1] Entered the NPI in the unshaded area of the field.
26	Patient's account number	**Optional:** Enter the client identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
27	Accept assignment	**Required** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*

Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. *Refer to:* Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP code of the facility where the service was provided.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the billing taxonomy number of the billing provider. [2]

6.5.5 CMS-1500 Instruction Table: Community First Health Plans Amendment

[1] Community First Health Plan Providers should enter the taxonomy code in Block Number 24j in the shaded area of the field in place of the TPI number.

[2] Community First Health Plan Providers should enter the taxonomy code of the billing provider in Block Number 33B in place of the TPI number.

6.6 UB-04 CMS-1450 Paper Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 paper claim form when requesting payment:

Provider Types
ASCs (hospital-based)
Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)
FQHCs ***Note:*** *Must use CMS-1500 when billing THSteps.*
Home health agencies
Hospitals • Inpatient (acute care, rehabilitation, military, and psychiatric hospitals) • Outpatient
Renal dialysis center
RHCs (freestanding and hospital-based) ***Note:*** *Must use CMS-1500 when billing THSteps.*