III.A. CMS 1500 Billing Form

The information listed below are the CMS 1500 fields that must be completed accurately and completely in order to avoid claim suspense or denial. A copy of a CMS 1500 form follows.

ITEM	Description
1	**Medicaid/Medicare/Other ID**. Enter 'X' in Group Healthplan (SSN or ID)
1a	**Insured's ID Number.** Enter the member's identification number as it appears on the Medi-Cal ID card. When submitting a claim for a newborn, enter the mother's ID number.
2	**Patient's Name.** Last Name, First Name, and Middle Initial. When submitting a claim for a newborn, enter the newborn's name or write the mother's last name followed by "Baby Boy" or "Baby Girl".
3	**Patient's Birth Date/Sex.** Enter the member's date of birth in the six-digit MMDDYY format. Enter an "X" in the "M" or "F" box.
4	**Insured's Name.** Not required unless billing for newborn using the mother's ID.
5	**Patient's Address/Telephone.** Enter the member's complete name and address and phone number.
6	**Patient's Relationship to Insured.** Not required but may be used when billing for an infant using the mother's ID by checking the child box.
7	**Insured's Address.** Not required.
8	**Patient Status.** Not required.
9	**Other Insured's Name.** Not required.
9a	**Other Insured's Policy or Group Number.** Not required.
9b	**Other Insured's Date of Birth.** Not required.
9c	**Employer's Name or School Name.** Not required.
9d	**Insurance Plan Name or Program Name.** Not required.

ITEM	Description
10	**Is Patient's Condition Related To:**
10a	**Employment?** Enter an "X" in the *YES* box *if* accident/injury is employment related. If YES is checked, the date of the accident must be entered in (Box 14) *Date of Current Illness*, *injury or Pregnancy*. Put an "X" in the *NO* box *if* accident/injury is not employment related.
10b	**Auto Accident?** Enter an "X" in the *YES* Box *if* accident/injury is Auto Related. If YES is checked, the date of the accident must be entered in (Box 14) *Date of Current Illness, injury or Pregnancy.* Put an "X" in the *NO* box *if* accident/injury is not Auto related.
10c	**Other Accident?** Enter an "X" in the *YES* box *if* related to an accident/injury. If YES is checked, the date of the accident must be entered in (Box 14) *Date of Current Illness, injury or Pregnancy.* Put an "X" in the *NO* box *if* it is not related to an accident/injury.
10d	**Claim Codes (Designated by NUCC).** Enter the amount of the member's share of cost (SOC) for the procedure, service or supply. Do not enter a decimal point or dollar sign.
11	**Insured's Policy Group or FECA Number.** Not required.
11a	**Insured's Date of Birth/Sex.** Not required.
11b	**Other Claim ID (Designated by NUCC).** Not required.
11c	**Insurance Plan Name or Program Name.** For Medicare/Medi-Cal crossover claims, enter the Medicare Carrier Code.
11d	**Is There Another Health Benefit Plan?** Enter an "X" in the Yes box if the member has Other Health Coverage (OHC). Eligibility under Medicare or a Medi-Cal Managed Care Plan is not considered OHC. If the other coverage had paid, enter the amount in the upper right side of this field. Do not enter a decimal point or dollar sign. Note: Be sure to attach the Other Carrier(s)/Medicare's EOMB, EOB, RA, showing their payment/denial. Make sure that the pay/deny explanation is included.
12	**Patient's or Authorized Person's Signature.** N/A
13	**Insured's or Authorized Person's Signature.** N/A

ITEM	Description

14 **Date of Current Illness, Injury or Pregnancy (LMP).** If applicable, enter the date of onset of the member's illness, the date of the accident/injury, or the date of the last menstrual period (LMP).

15 **Other Date.** N/A

16 **Dates Patient Unable to Work in Current Occupation.** N/A

17 **Name of Referring Physician or Other Source.** Indent to the right of the dotted line and enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the non-physician medical practitioner must be entered.

Note: Providers billing lab services for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.

17a **Unlabeled.**

17b **NPI.** Enter the National Provider Identifier. Boxes 17 and 17b MUST be completed by the following providers:

- **Clinical laboratory (services billed by laboratory)**
- **Durable Medical Equipment (DME) and medical supply**
- **Hearing aid dispenser**
- **Orthotist**
- **Prosthetist**
- **Nurse anesthetist**
- **Occupational therapist**
- **Physical therapist**
- **Podiatrist (when services are rendered in a Skilled Nursing Facility [NF] Level A or B)**
- **Portable X-ray**
- **Radiologist**
- **Speech pathologist**
- **Audiologist**
- **Pharmacies**

For additional information, please refer to the State Medi-Cal Provider Manual.

ITEM	Description

18 **Hospitalization Dates Related to Current Services.** Enter the dates of hospital admission and discharge if the services are related to a hospitalization. If the patient has not been discharged, leave the discharge date blank.

19 **Additional Claim Information (Designated by NUCC).** Use this area for procedures that require additional information or justification.

20 **Outside Lab.** N/A

Outside Lab Charges. N/A

21 **Diagnosis or Nature of Illness or Injury.** Relate A-L to service line below (24E).

ICD Ind. Enter the appropriate ICD indicator, either a "9" or "0", depending on the date of service for the claim. Claims submitted without a diagnosis code do not require an ICD indicator.

21.A **Diagnosis or Nature of Illness or Injury.** Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis including fourth through seventh characters if present (do not enter decimal point).

The following services are exempt from diagnosis descriptions and codes when they are the ONLY services billed on the claim:

- Anesthesia services
- Assistant surgeon services
- Medical supplies and materials (includes DME [except incontinence supplies]), hearing aids, orthotic and prosthetic appliances.
- Medical transportation
- Pathology services (referenced in the CPT-4 book)
- Radiology services (except: CAT scan, nuclear medicine, ultrasound, radiation therapy, and portable X-ray services, which REQUIRE diagnosis codes.)

  For additional information, please refer to the State Medi-Cal Provider manual.

21.B-21.L **Diagnosis or Nature of Illness or Injury.** If applicable, enter all letters and/or numbers of the ICD-10-CM code for any additional diagnosis including fourth through seventh characters if present (do not enter decimal point).

22 **Medicaid Resubmission Code/Original Ref. No.** Medicare status codes are required for Charpentier claims. In all other circumstances these codes are optional. The Medicare status codes are:

Code	Explanation
0	Under 65, does not have Medicare coverage
1*	Benefits exhausted
2*	Utilization committee denial or physician non-certification
3*	No prior hospital stay
4*	Facility denial
5*	Non-eligible provider
6*	Non-eligible recipient
7*	Medicare benefits denied or cut short by Medicare intermediary
8*	Non-covered services
9*	PSRO denial
L*	Medi-Medi Charpentier: Benefit Limitations
R*	Medi-Medi Charpentier: Rates
T*	Medi-Medi Charpentier: Both Rates and Benefit Limitations

*Documentation required. Refer to the Medicare/Medi-Cal Crossover Claims: CMS-1500 section in the appropriate Part 2 State Medi-Cal Provider Manual for additional information.

23 **Prior Authorization Number.** For services requiring a PHC Medi-Cal Treatment Authorization Request (TAR) or Referral Authorization (RAF), enter the PHC Medi-Cal TAR/RAF Number or CCS SAR Number. Services billed must match the services approved on the TAR/RAF.

24.1 **Claim Line** Note: Do not enter data in the shaded area except as noted for Boxes 24A, C, or D.

24A **Date(s) of Service.** Enter the date the service was rendered in the "From" and "To" boxes in the six-digit, MMDDYY (Month, Day, and Year) format. "From-Through" billing may be used for both consecutive and non-consecutive days of service when billing for the following services: Dialysis, Global Obstetrical Services, Radiation Therapy, and Ambulance Services.

National Drug Code (NDC) for Physician-Administered Drugs: In the shaded area, enter the product ID qualifier N4 followed by the 11-digits NDC (no spaces or hyphens). Refer to the Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions section in the State Medi-Cal Provider Manual for more information.

Universal Product Number (UPN) for disposable incontinence and medical supplies: In the shaded area, enter the appropriate UPN qualifier followed by the UPN. Please refer to the State Medi-Cal Provider Manual for additional information.

24B **Place of Service.** Enter one code from the list below, indicating where the service was rendered.

Code	Place of Service
02	Telehealth
11	Office
12	Home
20	Urgent Care Facility
21	Inpatient
22	Outpatient
23	Emergency Room (hospital)
24	Ambulatory Surgery Clinic
25	Birthing Center
31	Skilled Nursing Facility (SNF)
32	Nursing Facility (NF)
41	Ambulance (Land)
42	Ambulance (Air or Water)
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
55	Residential Substance Abuse Treatment Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

Note: If subacute care, specify the appropriate Place of Service and use modifier U2.

24C **EMG: Emergency or delay reason code:**

Delay Reason Code: If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim. (Refer to the PHC Billing Limits Instructions in the PHC Provider Manual.)

Emergency Code: Only one emergency indicator is allowed per claim, and must be placed in the bottom unshaded portion of Box 24C. Leave this box blank unless billing for emergency services. Enter an "X" if an Emergency Certification Statement is attached to this claim or entered in for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required prior authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist, dentist, or pharmacist's statement, describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient.

24D **Procedures, Services or Supplies/Modifier.** Enter the applicable procedure code (HCPCS or CPT-4) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) ** must be billed appropriately. PHC accepts up to four modifiers for a procedure on a single claim line. Enter modifiers directly after the procedure code without any spaces.

**National Correct Coding Initiative (NCCI): Do not submit multiple NCCI-associated modifiers on the same claim line. The claim will be denied. Do not submit an NCCI-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted. (See the Correct Coding Initiative: National section in the appropriate Part 2 manual.

Modifiers: For a listing of required and approved PHC modifier codes, refer to the PHC Provider Manual.

Physician-administered Drugs: PHC requires a National Drug Code (NDC) for all Physician-administered drugs submitted for payment consideration. Refer to the Physician-administered Drugs-NDC: CMS1500 Billing Instructions of the California Medi-Cal Provider Manual for more information.

Medical Supplies: Effective for dates of service on or after 4/1/09, PHC will follow Medi-Cal and require the use of a combination of HCPCS code and UPN information on all disposable medical supply claims with the exception of diabetic supplies, peak flow, inhalers, FAMPACT medical supplies and nutrition supplies. Please see the California Medi-Cal web site at www.medi-cal.ca.gov

Medicare Non-Covered Services: Medicare non-covered services are listed in the Medicare non-covered service codes section of the California

Medi-Cal Provider manual. Only those services listed in the Medicare non-covered sections may be billed directly to PHC. All others must be billed to Medicare first.

24E **Diagnosis Pointer.** Enter the diagnosis listed in Box 21 which applies to the service line.

24F **Charges.** Enter the usual and customary fee for service(s). Do not enter decimal point (.) or dollar sign ($). Enter the full dollar amount and cents even if the amount is even (e.g. If billing for $100, enter 10000 not 100.) If an item is a taxable medical supply include the applicable state and county sales tax.

24G **Days or Units.** Enter the number of medical visits or procedures, surgical lesions, hours of detention time, units of anesthesia time, items or units of service, etc. Size of field is 999. Do not enter decimal point (.). Providers billing for units of time should enter the time in 15-minute increments (e.g. for one hour, enter "4").

24H **EPSDT Family Planning.** Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

Code	Description
1	Family Planning/Sterilization (Sterilization Consent Form must be attached to the claim if code 1 is entered.)
2	Family Planning/Other
3	CHDP Screening Related

Please refer to the State Medi-Cal Provider Manual Family Planning section for further details.

24I **ID Qualifier for Rendering Provider.** Not required.

24J **Rendering Provider ID Number.** Enter the NPI for a rendering provider (unshaded area), if the provider is billing under a group NPI.

The rendering provider instructions apply to services rendered by the following providers:

Acupuncturists	Physician groups
Chiropractors	Physicians
Licensed audiologists	Podiatrists
Occupational therapists	Portable X-ray providers
Ophthalmologists	Prosthetists

Orthotists	Psychologists
Physical therapists	Radiology labs
	Speech pathologists

ITEM Description

24.2-24.6. Additional Claim Lines. Follow instructions above for each claim line.

25 Federal Tax I.D. Number

26 Patient's Account No. Enter the patient's medical record number or account number in this field. Whatever is entered here will appear on the PHC Remittance Advice Report (RA).

27 Accept Assignment. N/A

28 Total Charge. In full dollar amount, enter the total for all services. Do not enter decimal point (.) or dollar sign ($). Enter full dollar amount and cents even if the amount is even. (e.g. If billing $20, enter 2000).

29 Amount Paid. Enter the amount of payment received from the Other Health Coverage (Box 11D) and/or the patient's SOC amount. Do not enter decimal point (.) or dollar sign ($). Enter the full dollar amount and cents even if the amount is even. Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)/*Remittance Advice* (RA) when submitted with the claim.

30 Rsvd for NUCC Use. Enter the difference between *Total Charges and Amount Paid.* Do not enter a decimal point (.) or dollar sign ($). Enter the full dollar amount and cents even if the amount is even.

31 Signature of Physician or Supplier Including Degrees or Credentials. The claim must be signed and dated by the provider or a representative assigned by the provider.

An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.

32 Service Facility Location Information. Enter the provider name. Enter the provider address, without a comma between the city and state and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.

Note: Not required for clinical laboratories when billing for their own services.

32A Enter the NPI of the facility where the services were rendered.

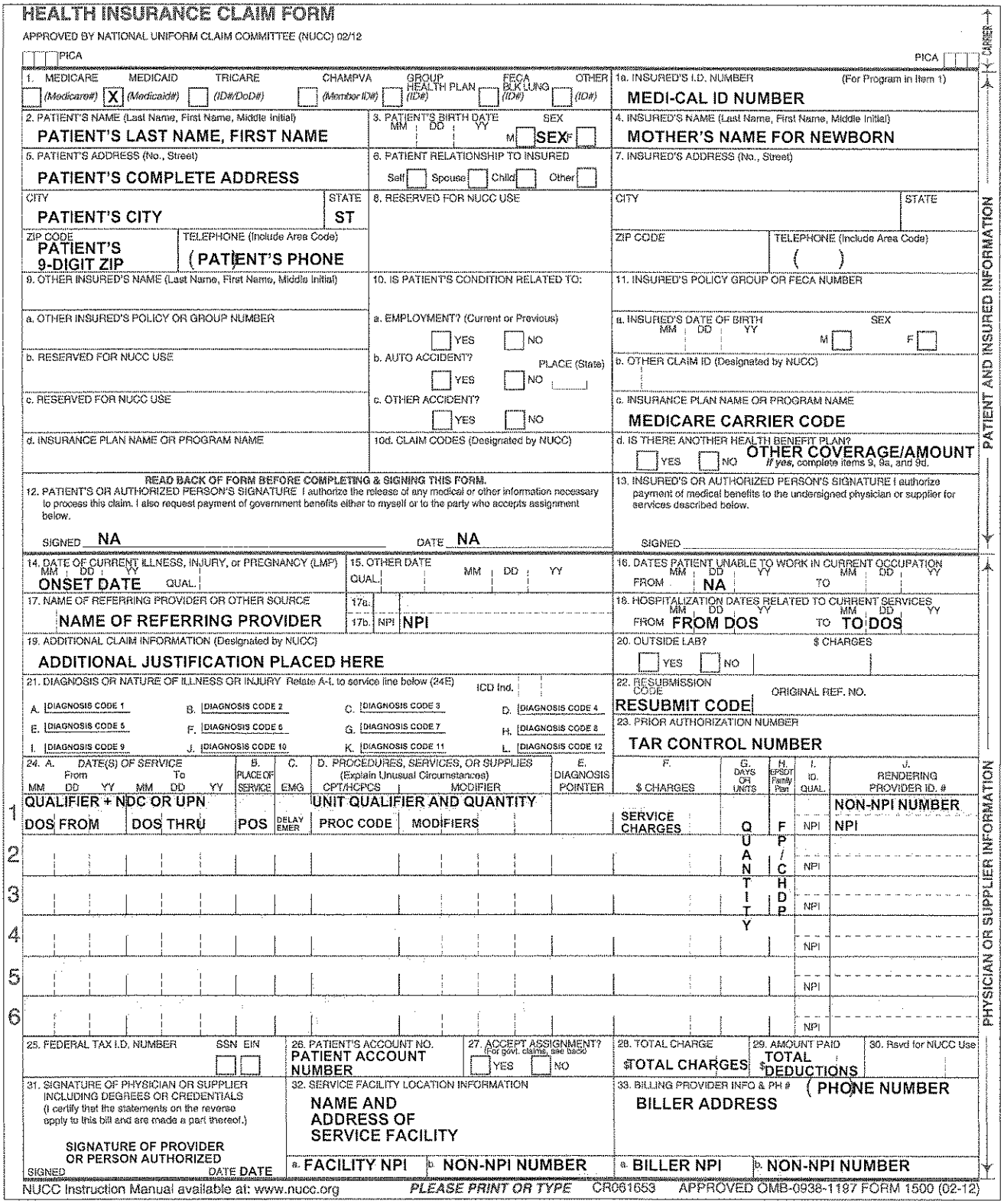
32B Enter the PHC additional provider number when required.

33 **Billing Provider Info and Phone Number.** Enter the provider name, address, ZIP code, and telephone number.

33A Enter the billing provider's NPI.

33B Used for PHC additional provider numbers when appropriate only. Enter the Medi-Cal provider number for the billing provider.

Note: Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) [X] 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): MEDI-CAL ID NUMBER

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MOTHER'S NAME FOR NEWBORN

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: PATIENT'S CITY STATE: ST

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: PATIENT'S 9-DIGIT ZIP TELEPHONE (Include Area Code): (PATIENT'S PHONE

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? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE CARRIER CODE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO OTHER COVERAGE/AMOUNT 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 NA DATE NA

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: ONSET DATE QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NAME OF REFERRING PROVIDER

17a.

17b. NPI NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL JUSTIFICATION PLACED HERE

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. DIAGNOSIS CODE 1 B. DIAGNOSIS CODE 2 C. DIAGNOSIS CODE 3 D. DIAGNOSIS CODE 4

E. DIAGNOSIS CODE 5 F. DIAGNOSIS CODE 6 G. DIAGNOSIS CODE 7 H. DIAGNOSIS CODE 8

I. DIAGNOSIS CODE 9 J. DIAGNOSIS CODE 10 K. DIAGNOSIS CODE 11 L. DIAGNOSIS CODE 12

22. RESUBMISSION CODE: RESUBMIT CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL 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. #
QUALIFIER + NDC OR UPN				UNIT QUALIFIER AND QUANTITY							NON-NPI NUMBER
DOS FROM	DOS THRU	POS	DELAY EMER	PROC CODE	MODIFIERS		SERVICE CHARGES	QUANTITY	F P/C HDP	NPI	NPI
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.: PATIENT ACCOUNT NUMBER

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

28. TOTAL CHARGE: $TOTAL CHARGES

29. AMOUNT PAID: $TOTAL DEDUCTIONS

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.)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED

SIGNED DATE DATE

32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY

a. FACILITY NPI b. NON-NPI NUMBER

33. BILLING PROVIDER INFO & PH #: BILLER ADDRESS (PHONE NUMBER

a. BILLER NPI b. NON-NPI NUMBER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 1. CMS-1500 Version 02/12: Medi-Cal-Required Fields.