REFERENCE B: FORM CMS-1500

CLAIM COMPLETION REQUIREMENTS FOR FORM CMS-1500

The Form CMS-1500 health insurance claim form is the prescribed form for billing Medicare Part B covered services by non-institutional providers and suppliers. The Form CMS-1500 can be used for both assigned and non-assigned claims, and is sometimes referred to as the American Medical Association (AMA) Form. It can be purchased in any version required (i.e., single sheet, snap-out, continuous, etc.) from the U.S. Government Printing Office (GPO), who can be contacted at 202-512-1800. An electronic version is also available at http://www.cms.hhs.gov/providers/edi/edi5.asp on the Web.

When filing Medicare Part B paper claims, providers are encouraged to type or machine-print all mandated claim fields on Form CMS-1500 and mail the claim to the local carrier. Certain carriers process claims using Optical Character Recognition (OCR), which is an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and interpret the characters entered in each field. It reads only typed or machine-printed data. Some carriers may require that only an original, red-ink Form CMS-1500 may be submitted because their Optical Character Recognition (OCR) software is unable to recognize black and white photocopies.

After the claims information is scanned, it is transmitted to the claims processing system, where it is validated and compared to other data until final processing occurs. To ensure accurate, quick claim processing, the following guidelines should be followed:

- Do not staple, clip, or tape anything to the Form CMS-1500 claim form;
- Place all necessary documentation in the envelope with the Form CMS-1500 claim form;
- Put the patient's name and Medicare number on each piece of documentation submitted;
- Use dark ink;
- Use only upper-case (CAPITAL) letters;
- Use 10 or 12 pitch (pica) characters and standard dot-matrix fonts;
- Do not mix character fonts on the same form;
- Do not use italics or script;
- Avoid using old or worn print bands or ribbons;
- Do not use dollar signs, decimals, or punctuation;
- Enter all information on the same horizontal plane within the designated field;
- Do not print, hand-write, or stamp any extraneous data on the form;
- Use only lift-off correction tape to make corrections;
- Ensure data is in the appropriate field and does not overlap into other fields;
- Remove pin-fed edges at side perforations; and
- Use only an original red-ink-on-white-paper Form CMS-1500 claim form.

Submission of paper claims that do not meet the carrier's requirements may delay payments.

EXAMPLE FORM CMS-1500

An example of the Form CMS-1500 is included within this section. A Key explaining how to enter date information into the Form CMS-1500 is included in Table B-1.

Table B-1. Key to Form CMS-1500.

Key	Description
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position year (e.g., 1998 = 98)
YYYY	4 position year (e.g., 1998 = 1998)
(MM|DD|YY) or (MM|DD|YYYY)	Indicate that a space must be reported between month, day, and year (e.g., 12|15|98 or 12|15|1998). This space is delineated by a dotted verticle line on the Form CMS01500.
(MMDDYY) or (MMDDYYYY)	Indicates that no space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | 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 _____

PHYSICIAN OR SUPPLIER INFORMATION

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 TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Updated instructions for completing the form may be found at http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf on the Web.

Item	Information To Be Entered	Notes
Patient and Insured Information		
Item 1 Health Insurance Coverage	Check the box next to the insurance option applicable to this claim.	
Item 1a Insurance ID Number	Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.	
Item 2 Patient's Name	Enter the patient's last name, first name, and middle initial (if any), as shown on the patient's Medicare card.	
Item 3 Patient's Birth Date and Sex	Enter the patient's eight-digit birth date (MM|DD|YYYY) and check the appropriate box to indicate the sex of the patient.	The following codes are used to indicate the patient's sex: F = Female; M = Male
Item 4 Insured's Name	**If Medicare is secondary to other insurance**, either through a patient's or spouse's employment or any other source, list the name of the insured. Enter the patient's last name, first name, and middle initial (if any). When the patient and insured are the same, enter "SAME". **If Medicare is primary, leave blank.**	
Item 5 Patient's Address	Enter the patient's mailing address and telephone number.	
Item 6 Patient's Relationship to the Insured	**If Item 4 was completed**, check the appropriate box to indicate the patient's relationship to the insured (self, spouse, child, other).	
Item 7 Insured's Address	**If Items 4-11 are completed**, enter the insured's address and telephone number. If this address is the same as the patient's, enter "SAME".	
Item 8 Patient Status	Check the appropriate box to indicate the patient's marital status (single, married, or other). Check the appropriate box to indicate the patient's employment status (employed, full-time student, or part-time student).	

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 9 Other Insured's Name	**If the Medigap enrollee's name is different from the insured's name (as entered in Item 2)**, enter the Medigap policy enrollee's last name, first name, and middle initial (if any). **Otherwise**, enter "SAME". **If no Medigap benefits are assigned**, leave blank.	**Only participating physicians and suppliers are to complete Item 9 and its subdivisions and only when the beneficiary wishes to assign benefits under a Medigap policy to the participating physician or supplier.** In the future, this item may be used for supplemental insurance plans. **If the beneficiary has assigned their benefits under a Medigap policy to a participating physician/supplier**, participating physicians/suppliers must enter information in Items 9a-d. **If you are a participating provider of service or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer**, all information in Items 9, 9a, 9b, and 9d must be complete and accurate. **Otherwise**, the Medicare carrier cannot forward the claim information to the Medigap insurer. Do not list other supplemental coverage in Items 9a-d at the time a Medicare claim is filed. **If the private insurer contracts with the carrier to send Medicare claim information electronically**, other supplemental claims will be automatically forwarded to the private insurer. **If the private insurer has not contracted to send claim information electronically**, the beneficiary must file own supplemental claim.

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 9a Other Insured's Policy or Group Number	Enter the Medigap insured's policy and/or group number, preceded by "MEDIGAP", "MG", or "MGAP".	Item 9d must be completed if a policy and/or group number was entered in Item 9a.
Item 9b Other Insured's Date of Birth and Sex	Enter the Medigap insured's eight-digit birth date (MM|DD|YYYY) and check the appropriate box to indicate the insured's sex.	The following codes are used to indicate the patient's sex: F = Female; M = Male
Item 9c Employer's Name or School Name	**If Item 9d contains a Medigap PAYERID number**, leave blank. **Otherwise**, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, a two letter postal abbreviation, and the ZIP Code copied from the Medigap insured's Medigap ID card.	**Example:** 1257 Anywhere Street Baltimore MD, 21204 Would be entered as "1257 Anywhere St MD 21204".
Item 9d Insurance Plan Name or Program Name	**If you entered a policy and/or group number into Item 9a**, you must enter the nine-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, enter the Medigap insurance program or plan name.	
Item 10a Employment (Current or Previous)?	Check Yes or No to indicate if the claim is covered under the patient's current or previous employment insurance.	If "Yes" is checked, this indicates that Medicare may be secondary to other insurance. Enter primary insurance information in Item 11.
Item 10b Auto Accident? Place (State)	Check Yes or No to indicate if the claim was a result of an auto accident. If checking Yes, enter the state postal abbreviation (e.g., VA for Virginia) in which the accident occurred.	
Item 10c Other Accident?	Check Yes or No to indicate if the claim is the result of an accident other than an auto accident.	
Item 10d Reserved for Local Use	**If the patient is entitled to Medicaid**, enter the patient's Medicaid number, preceded by "MCD".	

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 11 Insured's Policy Group or FECA Number	**If there is insurance primary to Medicare (i.e., Medicare is secondary)**, enter the insured's policy or group number and proceed to Items 11a-c. **If there is no insurance primary to Medicare (i.e., Medicare is primary)**, enter "NONE" and proceed to Item 12. **If the insured reports a terminating event with regard to insurance that had been primary to Medicare (e.g., insured retired)**, enter "NONE" and proceed to Item 11b.	**THIS ITEM MUST BE COMPLETED.** By completing this item, the physician/supplier acknowledges having made a good faith effort to determine if Medicare is the primary or secondary payer.
Item 11a Insured's Date of Birth	Enter insured's eight-digit birth date (MM|DD|YYYY) and sex if different than Item 3 input.	
Item 11b Employer's Name or School Name	Enter the employer's name, if applicable. If there is a change in the insured's insurance status, enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) change in status date, followed by a word describing the change.	If the person has retired, put "RETIRED" before the date.
Item 11c Insurance Plan Name or Program Name	Enter the nine-digit PAYER ID number of the primary insurer. If no Payer ID number exists, enter the complete primary payer's program or plan name. If the primary payer's Explanation of Benefits (EOB) does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.	
Item 11d	Leave blank. Not required by Medicare.	
Item 12 Patient's Signature	The patient or their authorized representative must enter a signature* in Item 12 unless a signature and/or a computer-generated signature is on file. If a signature is already on file, enter "SOF" or "SIGNATURE ON FILE". The signature authorizes release of medical information necessary to process the claim. Enter a date in either a six-digit	In lieu of signing the claim, the patient may provide the provider, physician, and/or supplier a signed statement to keep on file. If the patient is physically or mentally unable to sign, an authorized representative may sign on the patient's behalf. After the statement's signature line, the representative must write "by", followed by their name, address, relationship to

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 12 (con't) Patient's Signature	(MM|DD|YY), eight-digit (MM|DD|YYYY), or alphanumeric (January 1, 1998) format. *When an illiterate or physically handicapped enrollee signs by mark (i.e., with an "X"), a witness must enter his or her name and address next to the mark.	the patient, and the reason the patient cannot sign. This authorization is effective indefinitely unless the patient or patient's representative revokes the arrangement.
Item 13 Insured's or Authorized Person's Signature	**If Item 9 contains Medigap information**, the patient or their authorized representative must sign and date Item 13 to authorize payment of mandated Medigap benefits or the signature must be on file as a separate Medigap authorization.	The Medigap assignment on file in the participating provider of service/supplier's office must be insurer-specific. It may state that the authorization applies to all occasions of service until it is revoked.

ENTERING PROVIDER OF SERVICE OR SUPPLIER INFORMATION

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information		
Item 14 Date of Current: Illness (First Symptom); Injury (Accident); or Pregnancy (LMP)	Enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date of current illness, injury, or pregnancy. **For chiropractic services**, enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date of the initiation of the course of treatment, then enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date in Item 19.	
Item 15 If Patient Has Had Same or Similar Illness Give First Date	Leave blank. Not required by Medicare.	
Item 16 Dates Patient Unable to Work in Current Occupation	If the patient is employed and unable to work in current occupation, enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date range to indicate when the patient is unable to work.	An entry in this field may indicate employment-related insurance coverage.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 17 Name of Referring Physician or Other Source	Enter the name of the referring or ordering physician for an item or service, if applicable. **If a physician refers a patient to a surgeon**, the surgeon's name and National Provider Identifier (NPI) must be entered into Items 17 and 17a. If a physician extender or other limited licensed practitioner refers a patient for consultative services, the name and NPI of the supervising physician must be entered into Items 17 and 17a. **When a patient is referred to a physician who also orders and performs a diagnostic service**, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and NPI into Items 17 and 17a of the FIRST claim form. Enter the performing physician's name and NPI into Items 17 and 17a of the SECOND claim form.	**When a claim involves multiple referring and/or ordering physicians**, a separate Form CMS-1500 must be submitted for EACH ordering/referring physician. All claims for Medicare-covered services and items that result from a physician's order or referral must include the ordering/referring physician's name and NPI. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following: ❖ Diagnostic laboratory services; ❖ Diagnostic radiology services; ❖ Consultative services; and ❖ Durable Medical Equipment (DME). The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 17a ID Number of Referring Physician	Enter the CMS-assigned National Provider Identifier (NPI) of the referring/ordering physician listed in Item 17. Enter only the seven-digit base number and the one-digit check digit.	If the ordering/referring physician has not been assigned an NPI, one of the following surrogate NPIs must be used: ❖ RES00000 - for interns and residents who have not been assigned an NPI; ❖ RET00000 - for retired physicians who were not issued an NPI; ❖ VAD00000 - for physicians serving in the Veterans Health Administration (VHA) or the U.S. Armed Services; ❖ PHS00000 - for physicians serving in the Public Health or Indian Health Services; ❖ NPP00000 - for state-licensed nurse practitioners, clinical nurse specialists, or any other non-physician practitioner authorized

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 17a (con't) ID Number of Referring Physician		to order medical services or refer patients without approval or collaboration from a supervising physician; or ❖ OTH00000 - for when the ordering/referring physician has not been assigned an NPI and does not meet any of the above criteria. The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 18 Hospitalization Dates Related to Current Services	Enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date range to indicate when a medical service is furnished as a result of, or subsequent to, a related hospitalization.	
Item 19 Reserved for Local Use	Enter either a six-digit (MM|DD|YY) or an eight-digit (MM|DD|YYYY) date the patient was last seen and the PIN [National Provider Identifier (NPI) when it becomes effective] of his or her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file (see Chapter 15 of the *Medicare Benefits Policy Manual*). **When submitting for chiropractic services (if an X-ray, rather than a physical examination was the method used to demonstrate the subluxation)**, enter either a six-digit (MM|DD|YY) or an eight-digit (MM|DD|YYYY) X-ray date for chiropractor services. By entering an X-ray date and the initiation date for course of chiropractic treatment in Item	Item 19 can contain up to three conditions per claim. Additional conditions must be reported on a separate Form CMS-1500. The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005. Enter a concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise, an attachment must be submitted with the claim.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 19 (con't) Reserved for Local Use	14, the contractor is certifying that all the relevant information requirements (including level of subluxation) per Chapter 15 of the *Medicare Benefits Policy Manual*, are on file, along with the appropriate X-ray and all are available for carrier review. **When submitting a Not Otherwise Classified (NOC) drug claim**, enter the drug's name and dosage. **When modifier -99 (multiple modifiers) is entered in Item 24d**, enter all applicable modifiers. **If modifier -99 is entered on multiple line items of a single claim form**, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item. **When an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient**, enter the statement "Homebound". Refer to Chapters 15 and 16 of the Medicare *Benefit Policy Manual*, and Chapter 5 of the *Medicare General Information, Eligibility, and Entitlement Manual* for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient. **When the beneficiary absolutely refuses to assign benefits to a participating provider**, enter the statement, "Patient refuses to assign benefits". In this case, no payment may be made on the claim.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 19 (con't) Reserved for Local Use	**When billing services involving the testing of a hearing aid(s) are used to obtain intentional denials when other payers are involved**, enter the statement, "Testing for hearing aid". **When dental examinations are billed**, enter the specific surgery for which the exam is being performed. Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if Health Care Common Procedure Coding System (HCPCS) codes do not cover them. **When providers share post-operative care**, enter a six-digit (MM|DD|YY) or an eight-digit (MM|DD|YYYY) assumed and/or relinquished date for a global surgery claim. **If submitting a national emphysema treatment trial claim**, enter Demonstration ID number "30". **If the physician is performing a purchased interpretation of a diagnostic test**, enter the PIN (or NPI when effective). Refer to Chapter 1 of the Medicare Claims Processing Manual for additional information). Report the interpreting physician's PIN proceeded by a "PI" indicator (i.e., PI999999).	
Item 20 Outside Lab and $ Charges	**When billing for diagnostic tests subject to purchase price limitations**, check the "Yes" box. **If no purchased tests are included on the claim**, check the "No" box.	"Yes" indicates that an entity other than the entity billing for the service performed the diagnostic test and Item 32 must be completed. "No" indicates that no diagnostic checks are included on the claim.
Item 21 Diagnosis or Nature of Illness or Injury	Enter the patient's diagnosis/condition using up to four codes in priority order (primary, secondary condition). All physician specialties must use an	When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 21 (con't) Diagnosis or Nature of Illness or Injury	ICD-9-CM code number to the highest level of specificity.	All narrative diagnoses for non-physician specialties must be submitted on an attachment. An independent laboratory must enter a diagnosis only for limited coverage procedures. Access updated ICD-9-CM procedure and diagnosis codes billable to DMERCs at http://www.cms.hhs.gov/paymentsystems/icd9/default.asp on the Web.
Item 22 Medicaid Resubmission Code and Original Ref. No.	Leave blank. Not required by Medicare.	
Item 23 Prior Authorization Number	**For procedures requiring Professional Review Organization (PRO) prior approval**, enter the prior PRO authorization number. **When an investigational device is used in a Food and Drug Administration (FDA)-approved clinical trial**, enter the Investigational Device Exemption (IDE) number. **For physicians performing care plan oversight services**, enter the six-digit Medicare provider number of the home health agency (HHA) or hospice when Current Procedural Terminology (CPT) code 99375 or 99376 or Health Care Common Procedure Coding System (HCPCS) code G0064, G0065, or G0066 is billed. **For laboratory services billed by an entity performing Clinical Laboratory Improvement Act (CLIA) covered procedures**, enter the ten-digit CLIA certification number.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 24A Date(s) of Service	Enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date range to indicate when the patient received each procedure, service, or supply.	
Item 24B Place of Service	Enter the appropriate Place of Service (POS) code(s) (see Reference E) for each item used or service performed.	When a service is rendered to a hospital inpatient, use the inpatient hospital code.
Item 24C Type of Service	Medicare providers are not required to complete this item.	
Item 24D Procedures, Services, or Supplies	Enter the procedures, services, or supplies using the Health Care Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code. Enter the specific procedure code without a narrative description. When reporting a Not Otherwise Classified (NOC) code, include a narrative description in Item 19 if it will fit. Otherwise, submit the narrative in an attachment with the claim. **If modifier "-99" is entered on multiple line items of a single claim form**, all applicable modifiers for each line item containing a "-99" modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.	
Item 24E Diagnosis Code	Enter the diagnosis code reference number as shown in Item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 24E (con't) Diagnosis Code	**When multiple services are performed**, enter the primary reference number for each service (either 1, 2, 3, or 4). **If two or more diagnoses are required for a procedure code (e.g., pap smears)**, reference only one of the diagnoses in Item 21.	
Item 24F $ Charges	Enter the charge for each listed service.	
Item 24G Days or Units	**When From/To dates are shown for a series of identical services/supplies in Box 24A**, enter the number of days or units. **If only one service is provided**, enter numeral "1". **If multiple services are provided**, enter the actual number provided. **For anesthesia**, enter the elapsed time (minutes). Convert hours into minutes and enter the total minutes required for this procedure. **For oxygen**, suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems.	This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volumes. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). Round oxygen contents as follows: ❖ For stationary gas system rentals, indicate the oxygen contents in unit multiples of 50 cubic feet, rounded to the nearest increment of 50. **Example:** If 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" would be entered to indicate the nearest 50 cubic foot increment. ❖ For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10-pound increment. **Example:** If 63 pounds of liquid oxygen were delivered during the

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 24G (con't) Days or Units		applicable rental month billed, the unit entry "06" would be entered. ❖ For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or one liquid pound, respectively.
Item 24H EPSDG Family Plan	Leave blank. Not required by Medicare.	
Item 24I EMG	Leave blank. Not required by Medicare.	
Item 24J COB	**If the performing provider of service/supplier is a member of a group practice**, enter the first two digits of the National Provider Identifier (NPI).	The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 24K Reserved for Local Use	**If the performing provider of service/supplier is a member of a group practice**, enter the remaining six digits of the National Provider Identifier (NPI), including the two-digit location identifier.	When several different providers of service or suppliers within a group are billing on the same form, show the individual NPI in the corresponding line item. The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 25 Federal Tax ID Number	Enter the provider of service or supplier Federal Tax ID Number (Employer Identification Number) or Social Security Number (SSN). The participating provider of service or supplier Federal Tax ID Number is required for a mandated Medigap transfer.	
Item 26 Patient's Account Number	**OPTIONAL:** Enter the patient's account number assigned by the provider of service's or supplier's accounting system to assist in patient identification.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 27 Accept Assignment?	Check the appropriate item to indicate that the provider of service/supplier accepts assignment of Medicare benefits. If Medigap is indicated in Item 9 and Medigap payment authorization is given in Item 13, the provider of service/supplier must also be a Medicare participant and must accept assignment of Medicare benefits for all charges for all patients.	The following providers of service/suppliers can only be paid on an assignment basis: ❖ Clinical diagnostic laboratory services; ❖ Physician services to individuals dually entitled to Medicare and Medicaid; ❖ Participating physician/supplier services; ❖ Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers; ❖ Ambulatory surgical center (ASC) services for ASC procedures; ❖ Home dialysis supplies and equipment paid under Method II. ❖ Ambulance services; and ❖ Drugs and biologicals.
Item 28 Total Charge	Enter the total charges for the services (i.e., total of all charges in Item 24F).	
Item 29 Amount Paid	Enter the total amount the patient paid on covered services only.	
Item 30 Balance Due	Leave blank. Not required by Medicare.	
Item 31 Signature of Physician or Supplier Including Degrees or Credentials	Enter the signature of the provider of service or supplier, or his or her representative, and either the six-digit (MM|DD|YY), eight-digit (MM|DD|YYYY), or alphanumeric (e.g., January 1, 2003) date the form was signed.	
Item 32 Name and Address of Facility Where Services Were Rendered	**If services were provided in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office**, enter the name and address of the facility.	Providers of service (namely physicians) must identify the supplier's name, address, and NPI when billing for purchased diagnostic tests.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 32 (con't) Name and Address of Facility Where Services Were Rendered	**If the name and address where services were provided are the same as the biller's name and address shown in Item 33**, enter "SAME". **If a QB or QU modifier is billed to indicate that the service was rendered in a Health Professional Shortage Area (HPSA)**, enter the physical location where the service was rendered if other than at the patient's home. **If the address shown in Item 33 is in a HPSA and is the same location as where services were rendered**, enter "SAME". **If the supplier is a certified mammography screening center**, enter their six-digit Food and Drug Administration (FDA)-approved certification number.	When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier. This item is completed whether the supplier personnel performs the work at the physician's office or at another location. A QB modifier is used for services provided in a rural HPSA. A QU modifier is used for services provided in an urban HPSA.
Item 33 Physician's, Supplier's Billing Name, Address, ZIP Code, & Phone #	Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number. **If the performing provider of service/supplier is <u>NOT</u> a member of a group practice**, enter the National Provider Identifier (NPI), including the two-digit location identifier. **If the performing provider of service/supplier <u>IS</u> a member of a group practice**, enter the group NPI, including the two-digit location identifier.	The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.