CHAPTER 8:
Billing on the CMS 1500 Claim Form

Reviewed/Revised: 1/1/19, 10/1/2018

8.1 INTRODUCTION

The CMS 1500 claim form is used to bill for non-facility services, including professional services, freestanding surgery centers, transportation, durable medical equipment, ambulatory surgery centers and independent laboratories. This chapter covers paper claim submission only, for additional information on electronic claim submission, please see Chapter 7 section 7.4.

8.2 SUCCESSFUL CMS 1500 CLAIM SUBMISSION TIPS

Format:
- Do not print, hand-write, or stamp any extraneous data on the form.
- No hand-written corrections, no highlighting.
- Enter all information on the same horizontal plane within the designated field.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Use individual’s name in provider signature, not a facility or practice name.

Accurate information is key:
- Put member’s name and ID number as it appears on member card
- Include all applicable NPI numbers
- Indicate the correct address including ZIP code where service was rendered, making sure address was reported to Provider Services Representative and added to the Steward Health Choice Arizona provider database
- Ensure that the # of units/days and the dates of service range are not contradictory
- Ensure that the quantity indicated in the procedure codes description are not contradictory

Coding tips:
- Assign current ICD-10 diagnosis codes and code them to the highest level of specificity available.
  - Primary diagnosis (The primary diagnosis should describe the main condition or symptom of the patient).
  - Secondary/Additional Diagnosis
    - This field should be used if there is a secondary and/or additional conditions or symptoms that affect the treatment.
    - Diagnosis which relate to a previous illness and which have no
bearing on the current encounter should not be reported.
- The number of anesthesia minutes should always be reported on each claim in Field 24G.
- Use current valid CPT and HCPCS codes.
- Use current valid modifiers when necessary.

### 8.3 DOCUMENTATION REQUIREMENTS

Providers must include all required documentation with the claim submission. Failure to do so may result in denial of the claim. Steward Health Choice Arizona reserves the right to request additional documentation of the claim.

### 8.4 COMPLETING THE CMS 1500 CLAIM FORM

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.”

#### 1. Program Block

Check the second box labeled “Medicaid”:

- [ ] Medicare
- [x] Medicaid
- [ ] TRICARE
- [ ] CHAMPVA
- [ ] GROUP HEALTH PLAN
- [ ] FECA BLK LUNG
- [ ] OTHER

#### 1a. Insured’s ID Number

Enter the recipient’s AHCCCS ID number, whichever is applicable. If there are questions about eligibility or the AHCCCS ID number, review eligibility via the Steward Health Choice Arizona Provider Portal for ACC, Integrated Care Exchange (ICE) portal for RBHA members, or contact Steward Health Choice Arizona at (800) 322-8670 (see Chapter 2: Member Eligibility and Member Services).

1a. INSURED’S ID NUMBER (FOR PROGRAM IN ITEM 1)

A12345678

#### 2. Patient’s Name

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

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

Holliday, John H.

#### 3. Patient’s Date of Birth and Sex

Enter the recipient’s date of birth. Check the appropriate box to indicate the patient’s gender.
4. Insured's Name  
   Not required

5. Patient Address  
   Not required

6. Patient Relationship to Insured  
   Not required

7. Insured’s Address  
   Not required

8. Reserved for NUCC Use  
   Not required

9. Other Insured's Name  
   Required if applicable
   If the recipient has no coverage other than Steward Health Choice Arizona, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group  
   Required if applicable
   Enter the group number of the other insurance.

9a. Reserved for NUCC Use  
   Not required

9c. Reserved for NUCC Use  
   Not required

9d. Insurance Plan Name or Program Name  
   Required if applicable
   Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient’s Condition Related to:  
   Required if applicable
   Check "YES" or "NO" to indicate whether the patient’s condition is related to employment, an auto accident, or other accident. If the patient’s condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.
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)  
     Not Required

11. Insured’s Group Policy or FECA Number  
    Required if applicable

11a. Insured’s Date of Birth and Sex  
     Required if applicable

11b. Other Claim ID (Designated by NUCC)  
     Required if applicable

11c. Insurance Plan Name or Program Name  
     Required if applicable

11d. Is There Another Health Benefit Plan  
     Required if applicable

Check the appropriate box to indicate coverage other than Steward Health Choice Arizona. If “Yes” is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person’s Signature  
    Not required

13. Insured’s or Authorized Person’s Signature  
    Not required

14. Date of Illness or Injury  
    Required if applicable

15. Other Date  
    Not required

16. Dates Patient Unable to Work in Current Occupation  
    Not required

17. Qualifier / Name of Provider or Other Source  
    Required if applicable

If applicable, enter the Qualifier:
   DN Referring Provider
   DK Ordering Provider*
   DQ Supervising Provider

Then enter the Name of the Provider or Other Source
   * The ordering provider is required for:
     ▪ Laboratory
     ▪ Radiology
- Medical and Surgical Supplies
- Respiratory DME
- Enteral and Parenteral Therapy
- Drugs (J-codes)
- Temporary K codes
- Orthotics
- Prosthetics
- Temporary Q codes
- Vision codes (V-codes)
- 97001-97546

Ordering providers can be a M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

17a. ID Number of Provider  
Required if applicable

17b. NPI # of Referring Provider  
Required

18. Hospitalization Dates Related to Current Services  
Required on Inpatient stays

19. Additional Claim Information  
Required if applicable

20. Outside Lab and ($) Charges  
Not required

21. Diagnosis Codes  
Required
Enter at least one ICD-10 diagnosis code describing the recipient’s condition. Diagnosis codes are required to the 6th/7th character level when applicable, Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

Health providers must not use DSM-4 diagnosis codes

22. Medicaid Resubmission Code  
Required if applicable
Enter the appropriate code “A” (paper) “7” for adjustment or “8” for void to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the Steward Health Choice Arizona Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

This Item Number is not intended for use on original claim submissions.
DESCRIPTION: “Resubmission” means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

See Chapter 7: General Billing Rules, for information on resubmissions, adjustments, and voids.

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>030010004321</td>
</tr>
</tbody>
</table>

23. Prior Authorization Number  
Not required

See Chapter 6: Authorizations and Notifications, for information on prior authorization.

24A. Date(s) of Service and NDC (effective 7/1/12)  
Required/NDC if applicable

- In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

<table>
<thead>
<tr>
<th>24.</th>
<th>DATE(S) OF SERVICE</th>
<th>PLACE OF SERVICE</th>
<th>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>MODIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From M DD YY To M DD YY Place of Service EMG CPT/HCPCS</td>
<td>Explain Unusual Circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N400074115278 ML10</td>
<td>07 3/12 07 3/12</td>
<td>11</td>
<td>J1642</td>
<td></td>
</tr>
</tbody>
</table>

The beginning and ending service dates must be entered in the non-shaded area.

24B. Place of Service  
Required

Enter the two-digit code that describes the place of service.

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Place of Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Pharmacy</td>
<td>19 Off Campus-Outpatient Hospital</td>
</tr>
<tr>
<td>02 TeleHealth</td>
<td>20 Urgent Care Facility</td>
</tr>
<tr>
<td>03 School</td>
<td>21 Inpatient Hospital</td>
</tr>
<tr>
<td>04 Homeless shelter</td>
<td>23 ER - Hospital</td>
</tr>
<tr>
<td>05 IHS Free-standing Facility</td>
<td>24 ASC</td>
</tr>
<tr>
<td>06 IHS Provider-based</td>
<td>25 Birthing Center</td>
</tr>
<tr>
<td></td>
<td>49 Independent Clinic</td>
</tr>
<tr>
<td></td>
<td>50 FQHC</td>
</tr>
<tr>
<td></td>
<td>51 Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td></td>
<td>54 ICF/Mentally Retarded</td>
</tr>
<tr>
<td></td>
<td>55 Residential Substance Abuse Treat Facility</td>
</tr>
<tr>
<td></td>
<td>56 Psych Residential Treatment</td>
</tr>
</tbody>
</table>
For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment. The modifier field allows for four sets of 2 characters.
24E. Diagnosis Pointer  
Required  
Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the number of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), not the diagnosis code itself. If more than one number is entered, they should be in descending order of importance. To avoid claim denials, ensure the diagnosis code referenced in this field has a direct relationship to the CPT/HCPC code billed.

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>DIAGNOSIS POINTER</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1, 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24F. Charges $  
Required  
Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
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<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>DIAGNOSIS CODE</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>150 00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79 00</td>
<td></td>
<td></td>
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</tbody>
</table>

24G. Days or Units  
Required  
Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.
24H. EPSDT/Family Planning  

<table>
<thead>
<tr>
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<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>MODIFIER</td>
<td>DIAGNOSIS CODE</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

24I. ID Qualifier  

Required if applicable

24J. Rendering Provider ID Number  

Required

(SHARED AREA) – Use for COB INFORMATION  

Required if applicable

Use this SHARED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient’s Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount paid. Always attach a copy of the Medicare or other insurer’s EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied. See Chapter 14: Medicare and Other Insurance Liability, for details on billing claims with Medicare and other insurance.

24J. (NON SHARED AREA) – RENDERING PROVIDER ID #  

Required

Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI number.

For atypical provider types, the AHCCCS ID must be used. The provider number is required in 24J if the NPI listed in 33A is not the same as the provider rendering services.
25. Federal Tax
Enter the tax ID number and check the box labeled “EIN.” If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN.”

<table>
<thead>
<tr>
<th>25. FEDERAL TAX I.D. NUMBER</th>
<th>SSN</th>
<th>EIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>86-1234567</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. Patient Account Number
This is a number that the provider has assigned to uniquely identify this claim in the provider’s records. Steward Health Choice Arizona will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the Steward Health Choice Arizona CRN and the provider’s own accounting or tracking system.

27. Accept Assignment
Not required

28. Total Charge
Enter the total for all charges for all lines on the claim.

<table>
<thead>
<tr>
<th>27. ACCEPT ASSIGNMENT?</th>
<th>28. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. Rsvd for NUCC Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>(For govt claims. see back)</td>
<td>$ 179 00</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

29. Amount Paid
Enter the total amount that the provider has been paid for this claim by all sources other than Steward Health Choice Arizona. Do not enter any amounts expected to be paid by Steward Health Choice Arizona.

30. Reserved for NUCC Use
Not required

31. Signature and Date
Required
The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.
32. Name and Address of Facility

   Required if applicable
   Box 32 CANNOT contain a post office box address; it must be a physical address.

32a. Service Facility NPI

   Required if applicable
   If the service facility location is indicated, service facility NPI# must be entered.

32b. Service Facility AHCCCS ID# (Shaded area)

   Required if applicable

33. Billing Provider Name, Address and Phone Number

   Required
   Enter the provider name, address, and phone number. If a group is billing, enter the group biller’s name, address, and phone number.

33a. Billing Provider NPI Number

   Required if applicable

33b. Other ID – AHCCCS # (Shaded area) Registration #

   Required if applicable

** Note – NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, box 33b must be completed.

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

SIGNED John Doe   DATE 03/01/03

Doc Holliday
123 OK Corral Drive
Tombstone, AZ 85999
a. NPI   b.