CHAPTER 8:
Billing on the CMS 1500 Claim Form

Reviewed/Revised: 10/01/2018, 01/01/2019, 11/26//2019

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. FQHC services may also be billed on the CMS 1500 claim form. This chapter covers paper claim submission only, for additional information on electronic claim submission and general billing requirements please see Chapter 7 General Billing Rules.

The information is provided "as is" without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All models, methodologies and guidelines are undergoing continuous improvement and modification by Noridian Healthcare Solutions (Noridian) and the CMS. The most current edition of the information contained can be found on the Noridian website and the CMS website.

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.
- If required fields are not completed or if any fields are completed incorrectly, an error code will be identified for the claim. For example, if the date is “December 10, 2016” it must be recorded as 12/10/2016 (MM/DD/YYYY format).

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,
- 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
• If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456).

Coding tips:
• Assign current ICD-10 diagnosis codes and code them to the highest level of specificity available.
  o Primary diagnosis (The primary diagnosis should describe the main condition or symptom of the patient).
  o 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 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  [ ] 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, the AHCCCS online Eligibility System or contact Steward Health Choice Arizona at (800) 322-8670 (see Chapter 2: Member Eligibility and Member Services for additional guidance).

   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.

9b. 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.
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)  Not Required

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  Required
If the signature is on file, then stating that the signature is on file is acceptable.

13. Insured’s or Authorized Person’s Signature  Required if applicable

14. Date of Illness, Injury, or Pregnancy (LMP)  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
- Durable Medical Equipment
- 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** Not Required

19. **Additional Claim Information** Required if applicable

Any additional information required for the processing of a claim (that is not found in another field) shall be entered under the Additional Claim Information field. The standard format is as follows: FQHC/MSIC Indicator\Any other additional information.

For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the AHCCCS Fee-For-Service Provider Billing Manual.

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." 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**
If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456). 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. A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE(S) OF SERVICE</td>
<td>Place of Service</td>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>Modifier</td>
</tr>
<tr>
<td>From M DD YY To M DD YY</td>
<td>EMG</td>
<td>CPT/HCPCS</td>
<td>(Explain Unusual Circumstances)</td>
</tr>
<tr>
<td>N400074115278 ML10</td>
<td>07 01 12‡</td>
<td>07‡</td>
<td>01 12‡</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.

| 01 Pharmacy | 19 Off Campus-Outpatient Hospital | 49 Independent Clinic |
| 02 TeleHealth | 20 Urgent Care Facility | 50 FQHC |
| 03 School | 21 Inpatient Hospital | 51 Inpatient Psychiatric Facility |
| 04 Homeless shelter | 23 ER - Hospital | 54 ICF/Mentally Retarded |
| IHS Free-standing Facility | 24 ASC | 55 Residential Substance Abuse Treat Facility |

| 05 | 07 | 03 | 04 | 05 | 07 | 01 | 12‡ | 07‡ | 01 12‡ | 11‡ | J1642 |
| 06 | IHS Provider-based Tribal 638 Free-standing Facility |
| 07 | Tribal 638 Provider-based Facility |
| 11 | Office |
| 12 | Home |
| 13 | Assisted Living Facility |
| 14 | Group Home |
| 99 | Other Place of Service |
| 25 | Birthing Center |
| 26 | Military Treatment Facility |
| 31 | Skilled Nursing Facility |
| 32 | Nursing Facility |
| 33 | Custodial Care Facility |
| 34 | Hospice |
| 41 | Ambulance – Land |
| 42 | Ambulance – Air or Water |
| 56 | Psych Residential Treatment |
| 57 | Non-residential Substance Abuse Treatment Facility |
| 60 | Mass Immunization Center |
| 61 | Comprehensive Inpatient Rehabilitation Facility |
| 62 | Comprehensive Outpatient Rehabilitation Facility |
| 65 | ESRD Treatment Facility |
| 71 | State or Local Public Health Clinic |
| 72 | Rural Health Clinic |
| 81 | Independent Laboratory |

<table>
<thead>
<tr>
<th>24. A</th>
<th>DATE(S) OF SERVICE</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From MM DD YY</td>
<td>Place of Service</td>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>MODIFIER</td>
</tr>
<tr>
<td></td>
<td>To MM DD YY</td>
<td>EMG</td>
<td>CPT/HCPCS</td>
<td></td>
</tr>
</tbody>
</table>

### 24C. EMG - Emergency Indicator

Required if applicable
Mark this box with a “Y” if the service was an emergency service, regardless of where it was provided.

### 24D. Procedure and Procedure Modifier

Required
Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the same date of service, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.
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.

| DATE(S) OF Place PROCEDURE, SERVICES, OR SUPPLIES |
|------|---------|--------------------|
| From To of Service | CPT/HCPCS | MODIFIER |
| MM DD YY | MM DD YY | 71010 | 26 |

**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>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>DIAGNOSIS POINTER</th>
<th>$ CHARGES</th>
<th>DAYS OR UNITS</th>
<th>EPSDT Family Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></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>PROCEDURE, SERVICES, OR SUPPLIES</th>
<th>DIAGNOSIS CODE</th>
<th>$ CHARGES</th>
<th>DAYS OR UNITS</th>
<th>EPSDT Family Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>150</td>
<td>00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>79</td>
<td>00</td>
<td></td>
</tr>
</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.

---

8 | Steward Health Choice Arizona Provider Manual: Chapter 8
24H. EPSDT/Family Planning  Not Required

24I. ID Qualifier  Required if applicable

24J. Rendering Provider ID Number  Required

(SHADED AREA) – Use for Taxonomy Code  Required if applicable

Use this SHADED field to report the provider’s 10 digit alpha-numeric Taxonomy Number.

NOTE: Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer’s EOB to the claim.

See Chapter 14 Medicare and Other Insurance Liability for details on billing claims with Medicare and other insurance.

24J. (NON SHADED 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  Required

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.”
26. Patient Account Number 
Required if applicable
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 
Required
Enter the total for all charges for all lines on the claim.

<table>
<thead>
<tr>
<th>27. ACCEPT ASSIGNMENT? (For govt claims. see back)</th>
<th>28. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. Rsvd for NUCC Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>$ 179</td>
<td>$ 00</td>
<td>$</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When submitting a claim with multiple pages (a multi-page claim) all lines must be completed on the first page, before proceeding to the second page of the claim. (Please note that only the required fields on all lines will need filled in.)

Multi-page claims should have the total charges field left blank. The total charges should only be entered on the last page of a multi-page claim.

29. Amount Paid 
Required if applicable
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.

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
32. Name and Address of Facility
   Required if applicable
   If the pay to address and the service address are the same, then box 32 is not required unless the
   rendering provider has multiple locations under the same TIN# then box 32 is required. **Box 32
   CANNOT contain a post office box address; it must be a physical address.**

   32. SERVICE FACILITY LOCATION INFORMATION

   Arizona Hospital
   123 Main Street Scottsdale, AZ 85252  a. NPI  b

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 ID # (Shaded area)
   Required if applicable

   33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP
       CODE
       Doc Holliday
       123 OK Corral Drive
       Tombstone, AZ 85999
       a. NPI  b. Taxonomy Code

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