# CMS Manual System

## Pub 100-04 Medicare Claims Processing

**Transmittal 899**

**Department of Health & Human Services (DHHS)**

**Centers for Medicare & Medicaid Services (CMS)**

**Date: MARCH 31, 2006**

**Change Request 4293**

**SUBJECT: Revised Health Insurance Claim Form CMS-1500**

**I. SUMMARY OF CHANGES:** The current version of Form CMS-1500 (12-90) is being revised to accommodate the reporting of the National Provider Identifier (NPI). The revised version will be Form CMS-1500 (08-05). Chapter 26 is being revised to accommodate the updates for the new version. The following changes/updates are being made to Chapter 26: 1) An explanation of the revised version of the form is being added to Section 10, 2) Appropriate NPI language has been added to Fields 17 and 17a, 3) New field 17b is introduced and defined, 4) Information on surrogate UPINs has been removed and will be covered in a new IOM Chapter, 5) Introduction of the new shaded area of Field 24, 6) Introduction of the new Field 24j, 7) Appropriate NPI language has been added to Fields 32 and 33 and introduction of new fields 32a, 32b, 33a, and 33b, 8) Section 20 has been re-titled, 9) New section 30 has been added, and 10) Two Exhibits (1500 User Print file Specifications) have been added.

**NEW/REVISED MATERIAL:**
**EFFECTIVE DATE: October 1, 2006**
**IMPLEMENTATION DATE: October 2, 2006**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| **R** | 26/10/Health Insurance Claim Form CMS-1500 |
| **R** | 26/10/10.4/ Items 14-33 - Provider of Service or Supplier Information |
| **R** | 26/20/Patient's Request for Medicare Payment Form CMS-1490S |

| | |
|---|---|
| **N** | 26/30/Printing Standards and Print File Specifications Form CMS-1500 |

**III. FUNDING:**

**Funding for Medicare contractors is available through the regular budget process for costs required for implementation.**

**IV. ATTACHMENTS:**

Business Requirements
Manual Instruction

***Unless otherwise specified, the effective date is the date of service.***

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 899 | Date: March 31, 2006 | Change Request 4293 |
|---|---|---|---|

**SUBJECT: Revised Health Insurance Claim Form CMS-1500**

## I. GENERAL INFORMATION

The Form CMS-1500 (12-90) is being revised to accommodate the reporting of the National Provider Identifier (NPI). The work to complete this effort was headed up by the National Uniform Claim Committee (NUCC) of which CMS is a voting member. The intent of the NUCC's efforts was to best accommodate the NPI with minimal changes to the current claim form. Once the draft claim form was completed, it was subjected to two public comment periods to solicit industry feedback on the proposed changes to the form. The end result of the NUCC's work and the public comment period is the Form CMS-1500 (08-05) version. Included in this change request, you will find an attachment of the Form CMS-1500 (08-05). To receive copies of the revised form with the specifications needed for testing purposes, contact TFP Data Systems at JRMagdaleno@tfpdata.com.

The Form CMS-1500 (08-05) version will be effective October 1, 2006, but will not be mandated for use until February 1, 2007. Therefore, there will be a dual acceptability period of the current and the revised forms. In order to accommodate the dual acceptability period, there will be a need for both forms to be approved for use by the Office of Management and Budget (OMB). There are currently two clearance packages at OMB. The first package is a renewal of the current Form CMS-1500 (12-90) version and the other is a new collection of the Form CMS-1500 (08-05) version. The OMB number for the Form CMS-1500 (12-90) version is 0938-0008. The new Form CMS-1500 (08-05) collection will receive a brand new OMB collection number upon approval. The OMB renewal and approval are both expected between March and April 2006.

The following is the Form CMS-1500 form timeline:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised Form CMS-1500 (08/05).
- October 1, 2006 – January 31, 2007: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- February 1, 2007: The current Form CMS-1500 (12/90) version of the claim form is discontinued; only the revised Form CMS-1500 (08/05) is to be used. All rebilling of claims should use the revised Form CMS-1500 (08/05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12/90).

**A. Background:** The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at http://www.nucc.org/images/stories/PDF/change_log.pdf.

This instruction is directed to Medicare contractors only. A separate instruction will be released in the next few weeks to the shared system maintainers.

**B. Policy:** The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program and is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32.

## II. BUSINESS REQUIREMENTS

*"Shall" denotes a mandatory requirement*
*"Should" denotes an optional requirement*

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 4293.1 | Contractors shall make all necessary changes to your internal business processes to receive, sort, process, and store the new Form CMS-1500 (08-05). | | | X | X | | | | | |
| 4293.2 | Contractors shall make all necessary changes to your front end systems to accommodate the new Form CMS-1500 (08-05). | | | X | X | | | | | |
| 4293.3 | Contractors shall make all necessary changes to your Optical Character Recognition equipment to accommodate the new Form CMS-1500 (08-05). | | | X | X | | | | | |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| 4293.4 | Contractors shall post information regarding this instruction on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, information regarding this instruction | | | X | X | | | | | |

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. | | | | | | | | | |
| 4293.5 | A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | | X | X | | | | | |

## IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: N/A

| X-Ref Requirement # | Instructions |
|---|---|
| | |

### B. Design Considerations: N/A

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | |

### C. Interfaces: N/A

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

## V. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date***: October 1, 2006<br><br>**Implementation Date:** October 2, 2006<br><br>**Pre-Implementation Contact(s):** Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov<br><br>**Post-Implementation Contact(s):** Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov | **Funding for implementation activities will be provided to contractors through the regular budget process.** |

***Unless otherwise specified, the effective date is the date of service.**

# Medicare Claims Processing Manual

## Chapter 26 - Completing and Processing Form CMS-1500 Data Set

**Table of Contents**

***(Rev. 899, 03-31-06)***

# 10 - Health Insurance Claim Form CMS-1500

***(Rev. 899, Issued: 03-31-06; Effective: 10-01-06; Implementation: 10-02-06)***

The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc. To purchase them from the U.S. Government Printing Office, call (202) 512-1800.

*There are currently two versions of the Form CMS-1500. The current approved version of the form as of 2005 is the Form CMS-1500 (12/90). The current version is approved under the Office of Management and Budget (OMB) collection 0938-0008. The proposed version of the form will be the Form CMS-1500 (08/05) and is expected to receive OMB approval and receive a new collection number in April 2006. The current claim form is being revised to accommodate the implementation of the National Provider Identifier (NPI) which is scheduled for completion of the implementation in May 2007.*

*Because of the NPI dual usage period, there will be overlap between the use of the old and the new Form CMS-1500. Therefore, you will find information within this chapter that applies to both claim forms. The differences between the two forms will be noted within the body of the text that describes each of the items/boxes/fields of the Form CMS-1500. In addition to the text within the chapter, there are two exhibits at the end of this chapter that provide the print file specifications for each form. Exhibit 1 is the print file specification layout for the current Form CMS-1500 (12-90) and exhibit 2 is the print file specification layout for the Form CMS-1500 (08-05).*

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. It has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

There are a number of Part B services that have special limitations on payments or that require special methods of benefit computation. Carriers should monitor their processing systems to insure that they recognize the procedure codes that involve services with special payment limitations or calculation requirements. They should be able to identify separately billed procedure codes for physician services which are actually part of a global procedure code to prevent a greater payment than if the procedure were billed globally.

The following instructions must be completed or are required for a Medicare claim. Carriers should provide information on completing the Form CMS-1500 to all physicians and suppliers in their area at least once a year.

Providers may use these instructions for completing this form. The Form CMS-1500 has space for physicians and suppliers to provide information on other health insurance. This information can be used by carriers to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is a Medigap policy under which payments are made to a participating physician or supplier. (See Pub 100-05, Medicare Secondary Payer Manual, Chapter 3, and this manual, Chapter 28). Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31) are effective for providers and suppliers as of October 1, 1998.

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

| **Legend** | **Description** |
|---|---|
| MM | Month (e.g., December = 12) |
| DD | Day (e.g., Dec15 = 15) |
| YY | 2 position Year (e.g., 1998 = 98) |
| CCYY | 4 position Year (e.g., 1998 = 1998) |
| (MM \| DD \| YY) or (MM \| DD \| CCYY) | 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 vertical line on the Form CMS-1500) |
| (MMDDYY) or (MMDDCCYY) | 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. |

## 10.4 - Items 14-33 - Provider of Service or Supplier Information

*(Rev. 899, Issued: 03-31-06; Effective: 10-01-06; Implementation: 10-02-06)*

**Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.**

**Item 14 -** Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

**Item 15 -** Leave blank. Not required by Medicare.

**Item 16 -** If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

**Item 17 -** Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to

treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

**Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

**Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. *See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:*

- *Medicare covered services and items that are the result of a physician's order or referral;*
- *Parenteral and enteral nutrition;*
- *Immunosuppressive drug claims;*
- *Hepatitis B claims;*
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- *When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);*
- *When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;*
- *When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;*

***Item 17a –*** Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17. *The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available.*

***NOTE:*** *Field17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.*

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. *All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.*

***Item 17b Form CMS-1500 (08-05) –*** *Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.*

***NOTE:*** *Field17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.*

**Item 18 -** Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

**Item 19** – Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when an independent physical or occupational therapist submits claims or a physician providing routine foot care submits claims. For physical or occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. 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.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)
Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved. 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 HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the pin (or *NPI* when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, Chapter 1, Section 30.2.9.1 for additional information.)

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)

**Item 20 -** Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed

the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

**NOTE:** This is a required field when billing for diagnostic tests subject to purchase price limitations.

**Item 21 -** Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

**Item 22 -** Leave blank. Not required by Medicare.

**Item 23 -** Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number *(or NPI when effective)* of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician shall enter the Medicare facility provider number of the SNF in item 23.

**NOTE:** Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

***Item 24(Form CMS-1500 (08-05) –*** *The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. At this time, the shaded area is not used by Medicare. Future*

*guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.*

**Item 24A -** Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

**Item 24B -** Enter the appropriate place of service code(s) from the list provided in Section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

**NOTE:** When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

**Item 24C -** Medicare providers are not required to complete this item.

**Item 24D -** Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. *The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.*

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

**Item 24E -** 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. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

**Item 24F-** Enter the charge for each listed service.

**Item 24G -** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

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). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

**NOTE:** This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

**Item 24H** - Leave blank. Not required by Medicare.

**Item 24I** ***Form CMS-1500 (12-90)*** **-** Leave blank. Not required by Medicare.

***Item 24I Form CMS-1500 (08-05) –*** *Enter the ID qualifier 1C in the shaded portion.*

**Item 24J** ***Form CMS-1500 (12-90)*** **-** Leave blank. Not required by Medicare.

***Item 24J Form CMS-1500 (08-05)*** *– Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.*

*Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than October 1, 2006, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.*

**Item 24K** ***Form CMS-1500 (12-90)*** **-** Enter the PIN of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24k.

***Item 24K Form CMS-1500 (08-05) –*** *There is no Item 24K on this version.*

**Item 25 -** Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

**Item 26 -** Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

**Item 27 -** Check the appropriate block to indicate whether the provider of service or 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 or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims 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 services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

**Item 28 -** Enter total charges for the services (i.e., total of all charges in item 24f).

**Item 29 -** Enter the total amount the patient paid on the covered services only.

**Item 30 -** Leave blank. Not required by Medicare.

**Item 31 -** Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

**NOTE:** This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

**Item 32** ***Form CMS-1500 (12-90)*** **-** Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.

Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name address, or PIN of the location where the order was accepted must be entered (DMERC only).

This field is required. 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's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed, and the PIN.

***Item 32 Form CMS-1500 (08-05) -*** *Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.*

*Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.*

*For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.*

*For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. 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's personnel performs the work at the physician's office or at another location.*

*If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.*

*Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.*

***Item 32a Form CMS-1500 (08-05) –*** *Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.*

***Item 32b Form CMS-1500 (08-05) -*** *Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Effective May 23, 2007, and later, 32b is not to be reported.*

*Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests.*

*If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.*

*For durable medical, orthotic, and prosthetic claims, enter the PIN (of the location where the order was accepted) if the name and address was not provided in item 32 (DMERC only).*

**Item 33 -** Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

***Item 33a Form CMS-1500 (08-05) -*** *Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006. This is a required field.*

***Item 33b Form CMS-1500 (08-05) -*** *Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item. Enter the PIN for the performing provider of service/supplier who is* ***not*** *a member of a group practice. Enter the group PIN for the performing provider of service/supplier who is a member of a group practice. Enter the group UPIN, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.*

## 20 – *Patient's Request for Medicare Payment Form CMS-1490S*

***(Rev. 899, Issued: 03-31-06; Effective: 10-01-06; Implementation: 10-02-06)***

This form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration. Social Security offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims.

Although §1848(g)(4) of the Act requires physicians and suppliers to submit Part B Medicare claims for services furnished on or after September 1, 1990, contractors continue to accept, process, and pay for covered services submitted by beneficiaries on a Form CMS-1490S if there is no clear indication that the service provider intends to file a claim. An itemized bill for services on or after September 1, 1990, which clearly indicates the physician or supplier intends to file a Part B claim for the patient, may be returned to the beneficiary.

For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so or if one of the following situations applies:

- DME purchases from private sources;
- Cases in which a physician/supplier does not possess information essential for filing an MSP claim. Assume this is the case if the beneficiary files an MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;
- Services paid under the indirect payment procedure;
- Foreign claims;
- Services furnished by sanctioned physicians and suppliers which are approved for payment to the beneficiary per the Program Integrity Manual (PIM); and
- Other unusual or unique situations that are evaluated on a case-by-case basis.

If the contractor approves 11 or more Form CMS-1490S claims in a calendar month for services performed on or after September 1, 1990, by the same physician or supplier, monitor the provider's claims submissions and take appropriate action.

The contractor continues to stock Form CMS-1490S and, upon request, furnish beneficiaries with these forms. (Beneficiaries need these forms to file claims for services that physicians/suppliers are not required to submit (e.g., services prior to September 1, 1990), or refuse to submit to Part B on their behalf.)

## *30 – Printing Standards and Print File Specifications Form CMS-1500*

***(Rev. 899, Issued: 03-31-06; Effective: 10-01-06; Implementation: 10-02-06)***

*The National Uniform Claims Committee (NUCC) has approved the printing standards for Form CMS-1500 (08-05) paper claim. These standards are as follows:*

*The Form CMS-1500 (08-05) is designed to accommodate 10-pitch Pica type, 6 lines per inch vertical and 10 characters per inch (cpi) horizontal. Once adjusted to the left and right, PICA Alignment blocks in the first print line and characters appear within form lines as shown in the print file matrix.*

*Also provided on the Form CMS-1500 (08-05) is a position bar. This is a thick horizontal line that is at the base of the PICA alignment Boxes.*

*The Form CMS-1500 (08-05) is used in four different styles. Any one of these four styles may be printed from two negatives in concurrence with the layout that was approved by the NUCC. The face/back negative furnished must be used for all parts.*

*Compliance with these standards is required to facilitate the use of image processing technology such as Optical Character Recognition (OCR), facsimile transmission, and image storing.*

***Cut Sheet:***

*Size - 8.5 by 11 inches (plus or minus .0625 inch) or 217mm by 279mm (plus or minus 2mm).*

*Print - Face and back, head to head.*

*Margins –*

*Face-The top margin from the top edge of the form to the first print position is 1.33 inches or 34mm. The left margin is 0.3 inches to the left end of the first print position.*

*Back - 0.25 inch head and foot, 0.25 inch left and right or 6.35 mm head and foot, 6.35 mm left and right.*

*Offset -The X and Y offset for margins must not vary by more than +/-0.1 inch or 2.54 mm from sheet to sheet.*

*The X offset refers to the horizontal distance from the left edge of the paper to the beginning of the printing. The Y offset refers to the vertical distance between the top of the paper and the beginning of the printing.*

*Askewity - The askewity of the printed image must be no greater than 0.15mm in 100mm.*

*Paper Stock - Basis weight 20# recycled 30% postconsumer waste, White Environmental Paper Alliance (EPA) or approved paper stock. Smoothness: FS to be (140-160), or equivalent stock.*

*Ink color – Face – (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match, formerly known as Sinclair Valentine). There is to be no contamination with "Black" ink or pigment. Printer must maintain proper ink reflections limits of the OCR reader specified by the purchaser.*

*Back – Same as face.*

*Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.*

*Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.*

***Two Part Snap-set:***

*Size - Dimensions are same as Cut Sheet (detached 8.5 by 11 inches), plus top stub (.5 to .75 inches).*

*Print –*

*Part 1 - Face and back - head to head.*

*Part 2 - Face and back - head to head.*

*Margins - Same as Cut Sheet.*

*Askewity - Same as Cut Sheet.*

*Stock –*

*Part 1 - Carbonless, 20 CB – Recycled White*

*Part 2 - Any color that will not interfere with scanning of Part 1 sheet.*

*Ink Color –*

*Part 1 - (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match.*

*Part 2 - Any color that will not interfere with scanning of Part 1 sheet.*

*Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.*

*Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.*

*Perforations - Perforate top stub for disassembly of parts.*

***One Part Marginally Punched Continuous Form:***

*Size - Same dimensions as for Cut Sheet, plus 0.5 inch left and right, (overall: 9.5 by 11 inches, detached: 8.5 by 11 inches).*

*Print - Face and back, head to head.*

*Margins - On detached sheet, same as for Cut Sheet.*

*Askewity - On detached sheet, same as for Cut Sheet.*

*Paper Stock - Same as for Cut Sheet.*

*Ink Color - Same as for Cut Sheet (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match.*

*Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.*

*Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.*

*Perforations - Marginally 0.5 inch left and right, tear line horizontally every 11 inches.*

***Two Part Marginally Punched Continuous Forms:***

*Size - Same dimensions as for Cut Sheet, plus 0.5 inch left and right, (overall: 9.5 by 11 inches, detached: 8.5 by 11 inches).*

*Print –*

*Part 1 –Face and back, head to head.*

*Part 2 –Face and back, head to head.*

*Margins - On detached sheet, same as for Cut Sheet.*

*Askewity - On detached sheet, same as for Cut Sheet.*

*Paper Stock –*

*Part 1 - Carbonless, 20 CB – Recycled White*

*Part 2 - Any color or weight that does not interfere with scanning of part 1 sheet. Suggest the following sequence:*

*Paper Weight:*

*1st part is 20 CB - OCR Bond*

*2nd part is 14 CFB (if not last part)*

*Last part is 15CF*

*CB = Coated Back (Carbonless black print)*

*CFB = Coated Front and Back (Carbonless black print)*

*CF = Coated Front (Carbonless black print)*

*Ink color –*

*Part 1 - Same as for cut sheet, (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match.*

*Part 2 - Any color that will not interfere with scanning of the part 1 sheet.*

*Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.*

*Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.*

*Joining - Crimp left and right.*

*Perforations - Marginally 0.5 inch left and right, tear line horizontally every 11".*

***NOTE**: Users may determine the number of parts that are applicable to their needs. Up to four total parts are feasible on some printers; some other printers may limit the readability of multiple plies. Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red "dropout" ink.*

*Symbol: NUCC requires the use of an approved Form CMS-1500 in the formats provided displaying the 1500 symbol as approved by the NUCC. All printing of Form CMS-1500 must occur in accordance with the NUCC requirements.*

*Form Name - CMS-1500 Health Insurance Paper Claim Form, Approved by the National Uniform Claims Committee (NUCC).*

*Form Identification: The lower right-hand margin contains the approved OMB numbers and should be consistent throughout.*

*No modification is to be made to the Form CMS-1500 (08-05) without prior approval from the NUCC and CMS.*

# Exhibit - 1

## Form CMS-1500 (12/90) User Print File Specifications

| LINE | FIELD | LITERAL | FIELD TYPE* | BYTES | COLUMNS |
|---|---|---|---|---|---|
| 1 | | Left printer alignment block | M | 3 | 01-03 |
| 1 | | Right printer alignment block | M | 3 | 76-78 |
| 3 | 1 | Medicare | M | 1 | 01 |
| 3 | 1 | Medicaid | M | 1 | 08 |
| 3 | 1 | Champus | M | 1 | 15 |
| 3 | 1 | Champva | M | 1 | 24 |
| 3 | 1 | Group Health Plan | M | 1 | 31 |
| 3 | 1 | FECA Blk Lung | M | 1 | 39 |
| 3 | 1 | Other | M | 1 | 45 |
| 3 | 1a | Insured's ID Number | A/N | 29 | 50-78 |
| 5 | 2 | Patient's Name (Last, First, MI) | A | 29 | 01-29 |
| 5 | 3 | Patient's Birth Date (Month) | N | 2 | 31-32 |
| 5 | 3 | Patient's Birth Date (Day) | N | 2 | 34-35 |
| 5 | 3 | Patient's Birth (Year) | N | 4 | 37-40 |
| 5 | 3 | Sex-Male | A | 1 | 42 |
| 5 | 3 | Sex-Female | A | 1 | 47 |
| 5 | 4 | Insured Name (Last, First, MI) | A | 29 | 50-78 |
| 7 | 5 | Patient's Address (No., Street) | A/N | 29 | 01-29 |
| 7 | 6 | Patient Relationship to Insured (Self) | M | 1 | 33 |
| 7 | 6 | Patient Relationship to Insured (Spouse) | M | 1 | 38 |
| 7 | 6 | Patient Relationship to Insured (Child) | M | 1 | 42 |
| 7 | 6 | Patient Relationship to Insured (Other) | M | 1 | 47 |
| 7 | 7 | Insured's Address (No., Street) | A/N | 29 | 50-78 |
| 9 | 5 | Patient's Address (City) | A | 24 | 01-24 |
| 9 | 5 | Patient's Address (State) | A | 2 | 26-27 |
| 9 | 8 | Patient Status (Single) | M | 1 | 35 |
| 9 | 8 | Patient Status (Married) | M | 1 | 41 |
| 9 | 8 | Patient Status (OTher) | M | 1 | 47 |
| 9 | 7 | Insured's Address (City) | A | 23 | 50-72 |
| 9 | 7 | Insured's Address (State) | A | 2 | 74-75 |
| 11 | 5 | Patient's Address (Zip Code) | N | 9 | 01-09 |
| 11 | 5 | Patient's Area Code | N | 3 | 15-17 |
| 11 | 5 | Patient's Phone # | N | 7 | 19-25 |
| 11 | 8 | Patient Status (Employed) | M | 1 | 35 |
| 11 | 8 | Patient Status (Full Time Student) | M | 1 | 41 |
| 11 | 8 | Patient Status (Part Time Student) | M | 1 | 47 |
| 11 | 7 | Insured's Address (Zip Code) | N | 9 | 50-58 |
| 11 | 7 | Insured's Area Code | N | 3 | 65-67 |
| 11 | 7 | Insured's Phone # | N | 7 | 69-75 |
| 13 | 9 | Other Insured's Name (Last, First, MI) | A | 29 | 01-29 |
| 13 | 11 | Insured's Policy, Group or FECA Number | A/N | 29 | 50-78 |
| 15 | 9a | Other Insured's Policy or Group Number | A/N | 29 | 01-29 |
| 15 | 10a | Condition Related (Employment C/P, Yes) | M | 1 | 35 |
| 15 | 10a | Condition Related (Employment C/P, No) | M | 1 | 41 |
| 15 | 11a | Insured's Date of Birth (Month) | N | 2 | 54-55 |
| 15 | 11a | Insured's Date of Birth (Day) | N | 2 | 57-58 |
| 15 | 11a | Insured's Date of Birth (Year) | N | 4 | 60-63 |
| 15 | 11a | Sex-Male | M | 1 | 68 |
| 15 | 11a | Sex-Female | M | 1 | 75 |
| 17 | 9b | Other Insured's Date of Birth (Month) | N | 2 | 02-03 |
| 17 | 9b | Other Insured's Date of Birth (Day) | N | 2 | 05-06 |
| 17 | 9b | Other Insured's Date of Birth (Year) | N | 4 | 08-11 |
| 17 | 9b | Sex-Male | M | 1 | 18 |
| 17 | 9b | Sex-Female | M | 1 | 24 |
| 17 | 10b | Condition Related (Auto Accident-Yes) | M | 1 | 35 |
| 17 | 10b | Condition Related (Auto Accident-No) | M | 1 | 41 |
| 17 | 10b | Condition Related (Place-State) | A | 2 | 46-47 |
| 17 | 11b | Insured's Employer's Name or School Name | A | 29 | 50-78 |
| 19 | 9c | Other Insured's Employer's Name or School | A/N | 29 | 01-29 |
| 19 | 10c | Other Accident (Yes) | M | 1 | 35 |
| 19 | 10c | Other Accident (No) | M | 1 | 41 |
| 19 | 11c | Insured's Insurance Plan or PayerID | A/N | 29 | 50-78 |
| 21 | 9d | Other Insured's Insurance Plan Name or PayerID | A/N | 29 | 01-29 |
| 21 | 10d | Condition Relate (Reserved for Local Use) | A/N | 18 | 31-48 |
| 21 | 11d | Another Benefit Health Plan (Yes) | M | 1 | 52 |
| 21 | 11d | Another Benefit Health Plan (No) | M | 1 | 57 |
| 25 | 12 | Left Blank for Patient's Signature | | | |

| | | | | | |
|---|---|---|---|---|---|
| 25 | 13 | Left Blank for Insured's Signature | | | |
| 27 | 14 | Date of Current Illness, Injury, Pregnancy (Month) | N | 2 | 02-03 |
| 27 | 14 | Date of Current Illness, Injury, Pregnancy (Day) | N | 2 | 05-06 |
| 27 | 14 | Date of Current Illness, Injury, Pregnancy - (2 dgt. Year) | N | 2 | 08-09 |
| 27 | 14 | Date of Current Illness, Injury, Pregnancy - (4 dgt. Year) | N | 4 | 08-11 |
| 27 | 15 | First Date Has Had Same or Similar Illness (Month) | N | 2 | 37-38 |
| 27 | 15 | First Date Has Had Same or Similar Illness (Day) | N | 2 | 40-41 |
| 27 | 15 | First Date Has Had Same or Similar Illness - (2 dgt. Year) | N | 2 | 43-44 |
| 27 | 15 | First Date Has Had Same or Similar Illness - (4 dgt. Year) | N | 4 | 43-46 |
| 27 | 16 | Dates Patient Unable to Work (From Month) | N | 2 | 54-55 |
| 27 | 16 | Dates Patient Unable to Work (From Day) | N | 2 | 57-58 |
| 27 | 16 | Dates Patient Unable to Work - 2 dgt. (From Year) | N | 2 | 60-61 |
| 27 | 16 | Dates Patient Unable to Work - 4 dgt. (From Year) | N | 4 | 60-63 |
| 27 | 16 | Dates Patient Unable to Work (To Month) | N | 2 | 68-69 |
| 27 | 16 | Dates Patient Unable to Work (To Day) | N | 2 | 71-72 |
| 27 | 16 | Dates Patient Unable to Work - 2 dgt. (To Year) | N | 2 | 74-75 |
| 27 | 16 | Dates Patient Unable to Work - 4 dgt. (To Year) | N | 4 | 74-77 |
| 29 | 17 | Name of Referring Physician or Other Source | A | 26 | 01-26 |
| 29 | 17a | NPI Number of Referring Physician | A/N | 21 | 28-48 |
| 29 | 18 | Hospitalization Related Current Svcs (From Month) | N | 2 | 54-55 |
| 29 | 18 | Hospitalization Related Current Svcs (From Day) | N | 2 | 57-58 |
| 29 | 18 | Hospitalization Related Current Svcs - 2 dgt. (From Year) | N | 2 | 60-61 |
| 29 | 18 | Hospitalization Related Current Svcs - 4 dgt. (From Year) | N | 4 | 60-63 |
| 29 | 18 | Hospitalization Related Current Svcs (To Month) | N | 2 | 68-69 |
| 29 | 18 | Hospitalization Related Current Svcs (To Day) | N | 2 | 71-72 |
| 29 | 18 | Hospitalization Related Current Svcs - 2 dgt. (To Year) | N | 2 | 74-75 |
| 29 | 18 | Hospitalization Related Current Svcs - 4 dgt. (To Year) | N | 4 | 74-77 |
| 31 | 19 | Reserved for Local Use | A/N | 48 | 01-48 |
| 31 | 20 | Outside Lab (Yes) | M | 1 | 52 |
| 31 | 20 | Outside Lab (No) | M | 1 | 57 |
| 31 | 20 | $ Charges | N | 7 | 62-68 |
| 33 | 21.1 | Diagnosis or Nature of Illness or Injury (Code) | N | 3 | 03-05 |
| 33 | 21.1 | Diagnosis or Nature of Illness or Injury (Code) | N | 2 | 07-08 |
| 33 | 21.1 | Diagnosis | A | 20 | 10-29 |
| 33 | 21.3 | Diagnosis or Nature of Illness or Injury (Code) | N | 3 | 31-33 |
| 33 | 21.3 | Diagnosis or Nature of Illness or Injury (Code) | N | 2 | 35-36 |
| 33 | 21.3 | Diagnosis | A | 11 | 38-48 |
| 33 | 22 | Medicaid Resubmission Code | N | 8 | 53-60 |
| 33 | 22.2 | Original Reference Number | N | 13 | 66-78 |
| 35 | 21.2 | Diagnosis or Nature of Illness or Injury (Code) | N | 3 | 03-05 |
| 35 | 21.2 | Diagnosis or Nature of Illness or Injury (Code) | N | 2 | 07-08 |
| 35 | 21.2 | Diagnosis | A | 20 | 10-29 |
| 35 | 21.4 | Diagnosis or Nature of Illness or Injury (Code) | N | 3 | 31-33 |
| 35 | 21.4 | Diagnosis or Nature of Illness or Injury (Code) | N | 2 | 35-36 |
| 35 | 21.4 | Diagnosis | N | 11 | 38-48 |
| 35 | 23 | Prior Authorization Number | A/N | 29 | 50-78 |
| 39 | 24.1a | Date(s) of Service - 6 digit format (From Month) | N | 2 | 01-02 |
| 39 | 24.1a | Date(s) of Service - 6 digit format (From Day) | N | 2 | 04-05 |
| 39 | 24.1a | Date(s) of Service - 6 digit format (From Year) | N | 2 | 07-08 |
| 39 | 24.1a | Date(s) of Service - 8 digit format (From Month) | N | 2 | 01-02 |
| 39 | 24.1a | Date(s) of Service - 8 digit format (From Day) | N | 2 | 03-04 |
| 39 | 24.1a | Date(s) of Service - 8 digit format (From Year) | N | 4 | 05-08 |
| 39 | 24.1a | Date(s) of Service - 6 digit format (To Month) | N | 2 | 10-11 |
| 39 | 24.1a | Date(s) of Service - 6 digit format (To Day) | N | 2 | 13-14 |
| 39 | 24.1a | Date(s) of Service - 6 digit format (To Year) | N | 2 | 16-17 |
| 39 | 24.1a | Date(s) of Service - 8 digit format (To Month) | N | 2 | 10-11 |
| 39 | 24.1a | Date(s) of Service - 8 digit format (To Day) | N | 2 | 12-13 |
| 39 | 24.1a | Date(s) of Service - 8 digit format (To Year) | N | 4 | 14-17 |
| 39 | 24.1b | Place of Service | A/N | 2 | 19-20 |
| 39 | 24.1c | Type of Service | A/N | 2 | 22-23 |
| 39 | 24.1b | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 26-30 |
| 39 | 24.1c | Procedures, Svcs or Supplies (Modifier) | A/N | 2 | 32-33 |
| 39 | 24.1c | Procedures, Svcs or Supplies (Modifier) | A/N | 5 | 35-39 |
| 39 | 24.1e | Diagnosis Code | A/N | 6 | 42-47 |
| 39 | 24.1f | $ Charges | N | 5 | 50-54 |
| 39 | 24.1f | $ Charges | N | 2 | 56-57 |
| 39 | 24.1g | Days or Units | N | 3 | 59-61 |
| 39 | 24.1h | EPSDT Family Plan | A/N | 2 | 62-63 |
| 39 | 24.1i | EMG | A/N | 2 | 65-66 |
| 39 | 24.1j | COB | A/N | 2 | 68-69 |
| 39 | 24.1k | Reserved for Local Use | A/N | 8 | 70-77 |
| 41 | 24.2a | Dates of Service - 6 digit format (From Month) | N | 2 | 01-02 |
| 41 | 24.2a | Dates of Service - 6 digit format (From Day) | N | 2 | 04-05 |
| 41 | 24.2a | Dates of Service - 6 digit format (From Year) | N | 2 | 07-08 |

| | | | | | |
|---|---|---|---|---|---|
| 41 | 24.2a | Dates of Service - 8 digit format (From Month) | N | 2 | 01-02 |
| 41 | 24.2a | Dates of Service - 8 digit format (From Day) | N | 2 | 03-04 |
| 41 | 24.2a | Dates of Service - 8 digit format (From Year) | N | 4 | 05-08 |
| 41 | 24.2a | Dates of Service - 6 digit format (To Month) | N | 2 | 10-11 |
| 41 | 24.2a | Dates of Service - 6 digit format (To Day) | N | 2 | 13-14 |
| 41 | 24.2a | Dates of Service - 6 digit format (To Year) | N | 2 | 16-17 |
| 41 | 24.2a | Dates of Service - 8 digit format (To Month) | N | 2 | 10-11 |
| 41 | 24.2a | Dates of Service - 8 digit format (To Day) | N | 2 | 12-13 |
| 41 | 24.2a | Dates of Service - 8 digit format (To Year) | N | 4 | 14-17 |
| 41 | 24.2b | Place of Service | A/N | 2 | 19-20 |
| 41 | 24.2c | Type of Service | A/N | 2 | 22-23 |
| 41 | 24.2d | Procedures, Scvs or Supplies (CPT/HCPCS) | A/N | 5 | 26-30 |
| 41 | 24.2d | Procedures, Svcs or Supplies (Modifier) | A/N | 2 | 32-33 |
| 41 | 24.2d | Procedures, Svcs or Supplies (Modifier) | A/N | 5 | 35-39 |
| 41 | 24.2e | Diagnosis Code | A/N | 6 | 42-47 |
| 41 | 24.2f | $ Charges | N | 5 | 50-54 |
| 41 | 24.2f | $ Charges | N | 2 | 56-57 |
| 41 | 24.2g | Days or Units | N | 3 | 59-61 |
| 41 | 24.2h | EPSDT Family Plan | A/N | 2 | 62-63 |
| 41 | 24.2i | EMG | A/N | 2 | 65-66 |
| 41 | 24.2j | COB | A/N | 2 | 68-69 |
| 41 | 24.2k | Reserved for Local Use | A/N | 8 | 70-77 |
| 43 | 24.3a | Dates of Service - 6 digit format (From Month) | N | 2 | 01-02 |
| 43 | 24.3a | Dates of Service - 6 digit format (From Day) | N | 2 | 04-05 |
| 43 | 24.3a | Dates of Service - 6 digit format (From Year) | N | 2 | 07-08 |
| 43 | 24.3a | Dates of Service - 8 digit format (From Month) | N | 2 | 01-02 |
| 43 | 24.3a | Dates of Service - 8 digit format (From Day) | N | 2 | 03-04 |
| 43 | 24.3a | Dates of Service - 8 digit format (From Year) | N | 4 | 05-08 |
| 43 | 24.3a | Dates of Service - 6 digit format (To Month) | N | 2 | 10-11 |
| 43 | 24.3a | Dates of Service - 6 digit format (To Day) | N | 2 | 13-14 |
| 43 | 24.3a | Dates of Service - 6 digit format (To Year) | N | 2 | 16-17 |
| 43 | 24.3a | Dates of Service - 8 digit format (To Month) | N | 2 | 10-11 |
| 43 | 24.3a | Dates of Service - 8 digit format (To Day) | N | 2 | 12-13 |
| 43 | 24.3a | Dates of Service - 8 digit format (To Year) | N | 4 | 14-17 |
| 43 | 24.3b | Place of Service | A/N | 2 | 19-20 |
| 43 | 24.3c | Type of Service | A/N | 2 | 22-23 |
| 43 | 24.3d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 26-30 |
| 43 | 24.3d | Procedures, Svcs or Supplies (Modifier) | A/N | 2 | 32-33 |
| 43 | 24.3d | Procedures, Svcs or Supplies (Modifier) | A/N | 5 | 35-39 |
| 43 | 24.3e | Diagnosis Code | A/N | 6 | 42-47 |
| 43 | 24.3f | $ Charges | N | 5 | 50-54 |
| 43 | 24.3f | $ Charges | N | 2 | 56-57 |
| 43 | 24.3g | Days or Units | N | 3 | 59-61 |
| 43 | 24.3h | EPSDT Family Plan | A/N | 2 | 62-63 |
| 43 | 24.3i | EMG | A/N | 2 | 65-66 |
| 43 | 24.3j | COB | A/N | 2 | 68-69 |
| 43 | 24.3k | Reserved for Local Use | A/N | 8 | 70-77 |
| 45 | 24.4a | Dates of Service - 6 digit format (From Month) | N | 2 | 01-02 |
| 45 | 24.4a | Dates of Service - 6 digit format (From Day) | N | 2 | 04-05 |
| 45 | 24.4a | Dates of Service - 6 digit format (From Year) | N | 2 | 07-08 |
| 45 | 24.4a | Dates of Service - 8 digit format (From Month) | N | 2 | 01-02 |
| 45 | 24.4a | Dates of Service - 8 digit format (From Day) | N | 2 | 03-04 |
| 45 | 24.4a | Dates of Service - 8 digit format (From Year) | N | 4 | 05-08 |
| 45 | 24.4a | Dates of Service - 6 digit format (To Month) | N | 2 | 10-11 |
| 45 | 24.4a | Dates of Service - 6 digit format (To Day) | N | 2 | 13-14 |
| 45 | 24.4a | Dates of Service - 6 digit format (To Year) | N | 2 | 16-17 |
| 45 | 24.4a | Dates of Service - 8 digit format (To Month) | N | 2 | 10-11 |
| 45 | 24.4a | Dates of Service - 8 digit format (To Day) | N | 2 | 12-13 |
| 45 | 24.4a | Dates of Service - 8 digit format (To Year) | N | 4 | 14-17 |
| 45 | 24.4b | Place of Service | A/N | 2 | 19-20 |
| 45 | 24.4c | Type of Service | A/N | 2 | 22-23 |
| 45 | 24.4d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 26-30 |
| 45 | 24.4d | Procedures, Svcs or Supplies (Modifier) | A/N | 2 | 32-33 |
| 45 | 24.4d | Procedures, Svcs or Supplies (Modifier) | A/N | 5 | 35-39 |
| 45 | 24.4e | Diagnosis Code | A/N | 6 | 42-47 |
| 45 | 24.4f | $ Charges | N | 5 | 50-54 |
| 45 | 24.4f | $ Charges | N | 2 | 56-57 |
| 45 | 24.4g | Days or Units | N | 3 | 59-61 |
| 45 | 24.4h | EPSDT Family Plan | A/N | 2 | 62-63 |
| 45 | 24.4i | EMG | A/N | 2 | 65-66 |
| 45 | 24.4j | COB | A/N | 2 | 68-69 |
| 45 | 24.4k | Reserved for Local Use | A/N | 8 | 70-77 |
| 47 | 24.5a | Dates of Service - 6 digit format (From Month) | N | 2 | 01-02 |
| 47 | 24.5a | Dates of Service - 6 digit format (From Day) | N | 2 | 04-05 |

| | | | | | |
|---|---|---|---|---|---|
| 47 | 24.5a | Dates of Service - 6 digit format (From Year) | N | 2 | 07-08 |
| 47 | 24.5a | Dates of Service - 8 digit format (From Month) | N | 2 | 01-02 |
| 47 | 24.5a | Dates of Service - 8 digit format (From Day) | N | 2 | 03-04 |
| 47 | 24.5a | Dates of Service - 8 digit format (From Year) | N | 4 | 05-08 |
| 47 | 24.5a | Dates of Service - 6 digit format (To Month) | N | 2 | 10-11 |
| 47 | 24.5a | Dates of Service - 6 digit format (To Day) | N | 2 | 13-14 |
| 47 | 24.5a | Dates of Service - 6 digit format (To Year) | N | 2 | 16-17 |
| 47 | 24.5a | Dates of Service - 8 digit format (To Month) | N | 2 | 10-11 |
| 47 | 24.5a | Dates of Service - 8 digit format (To Day) | N | 2 | 12-13 |
| 47 | 24.5a | Dates of Service - 8 digit format (To Year) | N | 4 | 14-17 |
| 47 | 24.5b | Place of Service | A/N | 2 | 19-20 |
| 47 | 24.5c | Type of Service | A/N | 2 | 22-23 |
| 47 | 24.5d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 26-30 |
| 47 | 24.5d | Procedures, Svcs or Supplies (Modifier) | A/N | 2 | 32-33 |
| 47 | 24.5d | Procedures, Svcs or Supplies (Modifier) | A/N | 5 | 35-39 |
| 47 | 24.5e | Diagnosis Code | A/N | 6 | 42-47 |
| 47 | 24.5f | $ Charges | N | 5 | 50-54 |
| 47 | 24.5f | $ Charges | N | 2 | 56-57 |
| 47 | 24.5g | Days or Units | N | 3 | 59-61 |
| 47 | 24.5h | EPSDT Family Plan | A/N | 2 | 62-63 |
| 47 | 24.5i | EMG | A/N | 2 | 65-66 |
| 47 | 24.5j | COB | A/N | 2 | 68-69 |
| 47 | 24.5k | Reserved for Local Use | A/N | 8 | 70-77 |
| 49 | 24.6a | Dates of Service - 6 digit format (From Month) | N | 2 | 01-02 |
| 49 | 24.6a | Dates of Service - 6 digit format (From Day) | N | 2 | 04-05 |
| 49 | 24.6a | Dates of Service - 6 digit format (From Year) | N | 2 | 07-08 |
| 49 | 24.6a | Dates of Service - 8 digit format (From Month) | N | 2 | 01-02 |
| 49 | 24.6a | Dates of Service - 8 digit format (From Day) | N | 2 | 03-04 |
| 49 | 24.6a | Dates of Service - 8 digit format (From Year) | N | 4 | 05-08 |
| 49 | 24.6a | Dates of Service - 6 digit format (To Month) | N | 2 | 10-11 |
| 49 | 24.6a | Dates of Service - 6 digit format (To Day) | N | 2 | 13-14 |
| 49 | 24.6a | Dates of Service - 6 digit format (To Year) | N | 2 | 16-17 |
| 49 | 24.6a | Dates of Service - 8 digit format (To Month) | N | 2 | 10-11 |
| 49 | 24.6a | Dates of Service - 8 digit format (To Day) | N | 2 | 12-13 |
| 49 | 24.6a | Dates of Service - 8 digit format (To Year) | N | 4 | 14-17 |
| 49 | 24.6b | Place of Service | A/N | 2 | 19-20 |
| 49 | 24.6c | Type of Service | A/N | 2 | 22-23 |
| 49 | 24.6d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 26-30 |
| 49 | 24.6d | Procedures, Svcs or Supplies (Modifier) | A/N | 2 | 32-33 |
| 49 | 24.6d | Procedures, Svcs or Supplies (Modifier) | A/N | 5 | 35-39 |
| 49 | 24.6e | Diagnosis Code | A/N | 6 | 42-47 |
| 49 | 24.6f | $ Charges | N | 5 | 50-54 |
| 49 | 24.6f | $ Charges | N | 2 | 56-57 |
| 49 | 24.6g | Days or Units | N | 3 | 59-61 |
| 49 | 24.6h | EPSDT Family Plan | A/N | 2 | 62-63 |
| 49 | 24.6i | EMG | A/N | 2 | 65-66 |
| 49 | 24.6j | COB | A/N | 2 | 68-69 |
| 49 | 24.6k | Reserved for Local Use | A/N | 8 | 70-77 |
| 51 | 25 | Federal Tax ID Number | N | 15 | 1-15 |
| 51 | 25 | Federal Tax ID Number (SSN) | M | 1 | 17 |
| 51 | 25 | Federal Tax ID Number (EIN) | M | 1 | 19 |
| 51 | 26 | Patient's Account Number | A/N | 14 | 23-36 |
| 51 | 27 | Accept Assignment (Yes) | M | 1 | 38 |
| 51 | 27 | Accept Assignment (No) | M | 1 | 43 |
| 51 | 28 | Total Charge (Dollars) | N | 6 | 51-56 |
| 51 | 28 | Total Charge (Cents) | N | 2 | 58-59 |
| 51 | 29 | Amount Paid (Dollars) | N | 5 | 62-66 |
| 51 | 29 | Amount Paid (Cents) | N | 2 | 68-69 |
| 51 | 30 | Balance Due (Dollars) | N | 5 | 71-75 |
| 51 | 30 | Balance Due (Cents) | N | 2 | 77-78 |
| 53 | 32 | Name of Facility Where Svcs Rendered | A/N | 25 | 23-47 |
| 53 | 33 | Physician/Supplier Billing Name | A/N | 29 | 50-78 |
| 54 | 32 | Address of Facility Where Svcs Rendered | A/N | 25 | 23-47 |
| 54 | 33 | Physician/Supplier Address | A/N | 29 | 50-78 |
| 55 | 31 | Left Blank for Signature Physician/Supplier | | | |
| 55 | 32 | Address of Facility Where Svcs Rendered | A/N | 25 | 23-47 |
| 55 | 33 | Zip Code/Phone # of Physician/Supplier | A/N | 29 | 50-78 |
| 55 | 32 | Address of Facility Where Svcs Rendered | A/N | 25 | 23-47 |
| 56 | 33 | Provider of Service/Supplier NPI Number | A/N | 10 | 52-61 |
| 56 | 33 | Provider of Service/Supplier GRP NPI Number | A/N | 10 | 67-78 |

* M = mark (X), A = alpha, N = numeric

# Exhibit - 2

## Form CMS-1500 (08/05) User Print File Specifications

| LINE | FIELD | LITERAL | FIELD TYPE* | BYTES | COLUMNS |
|---|---|---|---|---|---|
| 1 | | Left printer alignment block | M | 3 | 01-03 |
| 1 | | Right printer alignment block | M | 3 | 77-79 |
| 3 | 1 | Medicare | M | 1 | 01 |
| 3 | 1 | Medicaid | M | 1 | 08 |
| 3 | 1 | Tricare Champus | M | 1 | 15 |
| 3 | 1 | Champva | M | 1 | 24 |
| 3 | 1 | Group Health Plan | M | 1 | 31 |
| 3 | 1 | FECA Blk Lung | M | 1 | 39 |
| 3 | 1 | Other | M | 1 | 45 |
| 3 | 1a | Insured's ID Number | A/N | 29 | 50-78 |
| 5 | 2 | Patient's Name (Last, First, MI) | A | 28 | 01-28 |
| 5 | 3 | Patient's Birth Date (Month) | N | 2 | 31-32 |
| 5 | 3 | Patient's Birth Date (Day) | N | 2 | 34-35 |
| 5 | 3 | Patient's Birth (Year) | N | 4 | 37-40 |
| 5 | 3 | Sex-Male | M | 1 | 42 |
| 5 | 3 | Sex-Female | M | 1 | 47 |
| 5 | 4 | Insured Name (Last, First, MI) | A | 29 | 50-78 |
| 7 | 5 | Patient's Address | A/N | 28 | 01-28 |
| 7 | 6 | Patient Relationship to Insured (Self) | M | 1 | 33 |
| 7 | 6 | Patient Relationship to Insured (Spouse) | M | 1 | 38 |
| 7 | 6 | Patient Relationship to Insured (Child) | M | 1 | 42 |
| 7 | 6 | Patient Relationship to Insured (Other) | M | 1 | 47 |
| 7 | 7 | Insured's Address | A/N | 29 | 50-78 |
| 9 | 5 | Patient's City | A | 24 | 01-24 |
| 9 | 5 | Patient's State | A | 3 | 26-28 |
| 9 | 8 | Patient Status (Single) | M | 1 | 35 |
| 9 | 8 | Patient Status (Married) | M | 1 | 41 |
| 9 | 8 | Patient Status (Other) | M | 1 | 47 |
| 9 | 7 | Insured's City | A | 23 | 50-72 |
| 9 | 7 | Insured's State | A | 4 | 74-77 |
| 11 | 5 | Patient's Zip Code | N | 12 | 01-12 |
| 11 | 5 | Patient's Area Code | N | 3 | 15-17 |
| 11 | 5 | Patient's Phone Number | N | 10 | 19-28 |
| 11 | 8 | Patient Status (Employed) | M | 1 | 35 |
| 11 | 8 | Patient Status (Full Time Student) | M | 1 | 41 |
| 11 | 8 | Patient Status (Part Time Student) | M | 1 | 47 |
| 11 | 7 | Insured's Zip Code | N | 12 | 50-61 |
| 11 | 7 | Insured's Area Code | N | 3 | 65-67 |
| 11 | 7 | Insured's Phone Number | N | 10 | 69-78 |
| 13 | 9 | Other Insured's Name (Last, First, MI) | A | 28 | 01-28 |
| 13 | 11 | Insured's Policy, Group or FECA Number | A/N | 29 | 50-78 |
| 15 | 9a | Other Insured's Policy or Group Number | A/N | 28 | 01-28 |
| 15 | 10a | Condition Related (Employment C/P, Yes) | M | 1 | 35 |
| 15 | 10a | Condition Related (Employment C/P, No) | M | 1 | 41 |
| 15 | 11a | Insured's Date of Birth (Month) | N | 2 | 53-54 |
| 15 | 11a | Insured's Date of Birth (Day) | N | 2 | 56-57 |
| 15 | 11a | Insured's Date of Birth (Year) | N | 4 | 59-62 |
| 15 | 11a | Sex-Male | M | 1 | 68 |
| 15 | 11a | Sex-Female | M | 1 | 75 |
| 17 | 9b | Other Insured's Date of Birth (Month) | N | 2 | 02-03 |
| 17 | 9b | Other Insured's Date of Birth (Day) | N | 2 | 05-06 |
| 17 | 9b | Other Insured's Date of Birth (Year) | N | 4 | 08-11 |
| 17 | 9b | Sex-Male | M | 1 | 18 |
| 17 | 9b | Sex-Female | M | 1 | 24 |
| 17 | 10b | Condition Related To: (Auto Accident-Yes) | M | 1 | 35 |
| 17 | 10b | Condition Related To: (Auto Accident-No) | M | 1 | 41 |
| 17 | 10b | Condition Related To: (Auto Accident-State) | A | 2 | 45-46 |
| 17 | 11b | Insured's Employer's Name or School Name | A/N | 29 | 50-78 |
| 19 | 9c | Other Insured's Employer's Name or School | A/N | 28 | 01-28 |
| 19 | 10c | Other Accident (Yes) | M | 1 | 35 |
| 19 | 10c | Other Accident (No) | M | 1 | 41 |
| 19 | 11c | Insured's Insurance Plan or PayerID | A/N | 29 | 50-78 |
| 21 | 9d | Other Insured's Insurance Plan Name or PayerID | A/N | 28 | 01-28 |
| 21 | 10d | (Reserved for Local Use) | A/N | 19 | 30-48 |
| 21 | 11d | Another Benefit Health Plan (Yes) | M | 1 | 52 |
| 21 | 11d | Another Benefit Health Plan (No) | M | 1 | 57 |
| 25 | 12 | Left Blank for Patient's Signature & Date | | | |
| 25 | 13 | Left Blank for Insured's Signature | | | |

| | | | | | |
|---|---|---|---|---|---|
| 27 | 14 | Date of Current Illness, Injury, Pregnancy (Month) | N | 2 | 02-03 |
| 27 | 14 | Date of Current Illness, Injury, Pregnancy (Day) | N | 2 | 05-06 |
| 27 | 14 | Date of Current Illness, Injury, Pregnancy - (Year) | N | 4 | 08-11 |
| 27 | 15 | First Date Has Had Same or Similar Illness (Month) | N | 2 | 37-38 |
| 27 | 15 | First Date Has Had Same or Similar Illness (Day) | N | 2 | 40-41 |
| 27 | 15 | First Date Has Had Same or Similar Illness - (Year) | N | 4 | 43-46 |
| 27 | 16 | Dates Patient Unable to Work (From Month) | N | 2 | 54-55 |
| 27 | 16 | Dates Patient Unable to Work (From Day) | N | 2 | 57-58 |
| 27 | 16 | Dates Patient Unable to Work (From Year) | N | 4 | 60-63 |
| 27 | 16 | Dates Patient Unable to Work (To Month) | N | 2 | 68-69 |
| 27 | 16 | Dates Patient Unable to Work (To Day) | N | 2 | 71-72 |
| 27 | 16 | Dates Patient Unable to Work (To Year) | N | 4 | 74-77 |
| 28 | 17a | Legacy Qualifier/Provider Number of Referring Physician | A/N | 19 | 30-48 |
| 29 | 17 | Name of Referring Physician or Other Source | A | 26 | 01-26 |
| 29 | 17b | NPI Number of Referring Physician | N | 17 | 32-48 |
| 29 | 18 | Hospitalization Related Current Svcs (From Month) | N | 2 | 54-55 |
| 29 | 18 | Hospitalization Related Current Svcs (From Day) | N | 2 | 57-58 |
| 29 | 18 | Hospitalization Related Current Svcs (From Year) | N | 4 | 60-63 |
| 29 | 18 | Hospitalization Related Current Svcs (To Month) | N | 2 | 68-69 |
| 29 | 18 | Hospitalization Related Current Svcs (To Day) | N | 2 | 71-72 |
| 29 | 18 | Hospitalization Related Current Svcs (To Year) | N | 4 | 74-77 |
| 30 | 19 | Reserved for Local Use | A/N | 35 | 14-48 |
| 31 | 19 | Reserved for Local Use | A/N | 48 | 01-48 |
| 31 | 20 | Outside Lab (Yes) | M | 1 | 52 |
| 31 | 20 | Outside Lab (No) | M | 1 | 57 |
| 31 | 20 | $ Charges | N | 8/8 | 62-78 |
| 33 | 21.1 | Diagnosis or Nature of Illness or Injury (Code) | A/N | 8 | 03-10 |
| 33 | 21.3 | Diagnosis or Nature of Illness or Injury (Code) | A/N | 8 | 30-37 |
| 33 | 22 | Medicaid Resubmission Code | A/N | 11 | 50-60 |
| 33 | 22.2 | Original Reference Number | A/N | 18 | 61-78 |
| 35 | 21.2 | Diagnosis or Nature of Illness or Injury (Code) | A/N | 8 | 03-10 |
| 35 | 21.4 | Diagnosis or Nature of Illness or Injury (Code) | A/N | 8 | 30-37 |
| 35 | 23 | Prior Authorization Number | A/N | 29 | 50-78 |
| 38 | 24 | Line Detail Narrative | A/N | 63 | 01-63 |
| 38 | 24.1i | Legacy Qualifier Rendering Provider | A/N | 2 | 65-66 |
| 38 | 24.1j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 39 | 24.1a | Date(s) of Service - (From Month) | N | 2 | 01-02 |
| 39 | 24.1a | Date(s) of Service - (From Day) | N | 2 | 04-05 |
| 39 | 24.1a | Date(s) of Service - (From Year) | N | 2 | 07-08 |
| 39 | 24.1a | Date(s) of Service - (To Month) | N | 2 | 10-11 |
| 39 | 24.1a | Date(s) of Service - (To Day) | N | 2 | 13-14 |
| 39 | 24.1a | Date(s) of Service - (To Year) | N | 2 | 16-17 |
| 39 | 24.1b | Place of Service | A/N | 2 | 19-20 |
| 39 | 24.1c | EMG | A | 2 | 22-23 |
| 39 | 24.1d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 25-30 |
| 39 | 24.1d | Procedures, Svcs or Supplies (Modifier 1) | A/N | 2 | 33-34 |
| 39 | 24.1d | Procedures, Svcs or Supplies (Modifier 2) | A/N | 5 | 36-37 |
| 39 | 24.1d | Procedures, Svcs or Supplies (Modifier 3) | A/N | 2 | 39-40 |
| 39 | 24.1d | Procedures, Svcs or Supplies (Modifier 4) | A/N | 5 | 42-43 |
| 39 | 24.1e | Diagnosis Pointer | N | 6 | 45-48 |
| 39 | 24.1f | $ Charges | N | 8 | 50-57 |
| 39 | 24.1g | Days or Units | N | 3 | 59-61 |
| 39 | 24.1h | EPSDT Family Plan | A | 1 | 63 |
| 39 | 24.1i | Legacy Qualifier Rendering Provider (Leave Blank) | A/N | 0 | |
| 39 | 24.1j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 40 | 24 | Line Detail Narrative | A/N | 63 | 01-63 |
| 40 | 24.2i | Legacy Qualifier Rendering Provider | A/N | 2 | 65-66 |
| 40 | 24.2j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 41 | 24.2a | Date(s) of Service - (From Month) | N | 2 | 01-02 |
| 41 | 24.2a | Date(s) of Service - (From Day) | N | 2 | 04-05 |
| 41 | 24.2a | Date(s) of Service - (From Year) | N | 2 | 07-08 |
| 41 | 24.2a | Date(s) of Service - (To Month) | N | 2 | 10-11 |
| 41 | 24.2a | Date(s) of Service - (To Day) | N | 2 | 13-14 |
| 41 | 24.2a | Date(s) of Service - (To Year) | N | 2 | 16-17 |
| 41 | 24.2b | Place of Service | A/N | 2 | 19-20 |
| 41 | 24.2c | EMG | A | 2 | 22-23 |
| 41 | 24.2d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 25-30 |
| 41 | 24.2d | Procedures, Svcs or Supplies (Modifier 1) | A/N | 2 | 33-34 |
| 41 | 24.2d | Procedures, Svcs or Supplies (Modifier 2) | A/N | 5 | 36-37 |
| 41 | 24.2d | Procedures, Svcs or Supplies (Modifier 3) | A/N | 2 | 39-40 |
| 41 | 24.2d | Procedures, Svcs or Supplies (Modifier 4) | A/N | 5 | 42-43 |
| 41 | 24.2e | Diagnosis Pointer | N | 6 | 45-48 |
| 41 | 24.2f | $ Charges | N | 8 | 50-57 |
| 41 | 24.2g | Days or Units | N | 3 | 59-61 |

| | | | | | |
|---|---|---|---|---|---|
| 41 | 24.2h | EPSDT Family Plan | A | 1 | 63 |
| 41 | 24.2i | Legacy Qualifier Rendering Provider (Leave Blank) | A/N | 0 | |
| 41 | 24.2j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 42 | 24 | Line Detail Narrative | A/N | 63 | 01-63 |
| 42 | 24.3i | Legacy Qualifier Rendering Provider | A/N | 2 | 65-66 |
| 42 | 24.3j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 43 | 24.3a | Date(s) of Service - (From Month) | N | 2 | 01-02 |
| 43 | 24.3a | Date(s) of Service - (From Day) | N | 2 | 04-05 |
| 43 | 24.3a | Date(s) of Service - (From Year) | N | 2 | 07-08 |
| 43 | 24.3a | Date(s) of Service - (To Month) | N | 2 | 10-11 |
| 43 | 24.3a | Date(s) of Service - (To Day) | N | 2 | 13-14 |
| 43 | 24.3a | Date(s) of Service - (To Year) | N | 2 | 16-17 |
| 43 | 24.3b | Place of Service | A/N | 2 | 19-20 |
| 43 | 24.3c | EMG | A | 2 | 22-23 |
| 43 | 24.3d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 25-30 |
| 43 | 24.3d | Procedures, Svcs or Supplies (Modifier 1) | A/N | 2 | 33-34 |
| 43 | 24.3d | Procedures, Svcs or Supplies (Modifier 2) | A/N | 5 | 36-37 |
| 43 | 24.3d | Procedures, Svcs or Supplies (Modifier 3) | A/N | 2 | 39-40 |
| 43 | 24.3d | Procedures, Svcs or Supplies (Modifier 4) | A/N | 5 | 42-43 |
| 43 | 24.3e | Diagnosis Pointer | N | 6 | 45-48 |
| 43 | 24.3f | $ Charges | N | 8 | 50-57 |
| 43 | 24.3g | Days or Units | N | 3 | 59-61 |
| 43 | 24.3h | EPSDT Family Plan | A | 1 | 63 |
| 43 | 24.3i | Legacy Qualifier Rendering Provider (Leave Blank) | A/N | 0 | |
| 43 | 24.3j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 44 | 24 | Line Detail Narrative | A/N | 63 | 01-63 |
| 44 | 24.4i | Legacy Qualifier Rendering Provider | A/N | 2 | 65-66 |
| 44 | 24.4j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 45 | 24.4a | Date(s) of Service - (From Month) | N | 2 | 01-02 |
| 45 | 24.4a | Date(s) of Service - (From Day) | N | 2 | 04-05 |
| 45 | 24.4a | Date(s) of Service - (From Year) | N | 2 | 07-08 |
| 45 | 24.4a | Date(s) of Service - (To Month) | N | 2 | 10-11 |
| 45 | 24.4a | Date(s) of Service - (To Day) | N | 2 | 13-14 |
| 45 | 24.4a | Date(s) of Service - (To Year) | N | 2 | 16-17 |
| 45 | 24.4b | Place of Service | A/N | 2 | 19-20 |
| 45 | 24.4c | EMG | A | 2 | 22-23 |
| 45 | 24.4d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 25-30 |
| 45 | 24.4d | Procedures, Svcs or Supplies (Modifier 1) | A/N | 2 | 33-34 |
| 45 | 24.4d | Procedures, Svcs or Supplies (Modifier 2) | A/N | 5 | 36-37 |
| 45 | 24.4d | Procedures, Svcs or Supplies (Modifier 3) | A/N | 2 | 39-40 |
| 45 | 24.4d | Procedures, Svcs or Supplies (Modifier 4) | A/N | 5 | 42-43 |
| 45 | 24.4e | Diagnosis Pointer | N | 6 | 45-48 |
| 45 | 24.4f | $ Charges | N | 8 | 50-57 |
| 45 | 24.4g | Days or Units | N | 3 | 59-61 |
| 45 | 24.4h | EPSDT Family Plan | A | 1 | 63 |
| 45 | 24.4i | Legacy Qualifier Rendering Provider (Leave Blank) | A/N | 0 | |
| 45 | 24.4j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 46 | 24 | Line Detail Narrative | A/N | 63 | 01-63 |
| 46 | 24.5i | Legacy Qualifier Rendering Provider | A/N | 2 | 65-66 |
| 46 | 24.5j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 47 | 24.5a | Date(s) of Service - (From Month) | N | 2 | 01-02 |
| 47 | 24.5a | Date(s) of Service - (From Day) | N | 2 | 04-05 |
| 47 | 24.5a | Date(s) of Service - (From Year) | N | 2 | 07-08 |
| 47 | 24.5a | Date(s) of Service - (To Month) | N | 2 | 10-11 |
| 47 | 24.5a | Date(s) of Service - (To Day) | N | 2 | 13-14 |
| 47 | 24.5a | Date(s) of Service - (To Year) | N | 2 | 16-17 |
| 47 | 24.5b | Place of Service | A/N | 2 | 19-20 |
| 47 | 24.5c | EMG | A | 2 | 22-23 |
| 47 | 24.5d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 25-30 |
| 47 | 24.5d | Procedures, Svcs or Supplies (Modifier 1) | A/N | 2 | 33-34 |
| 47 | 24.5d | Procedures, Svcs or Supplies (Modifier 2) | A/N | 5 | 36-37 |
| 47 | 24.5d | Procedures, Svcs or Supplies (Modifier 3) | A/N | 2 | 39-40 |
| 47 | 24.5d | Procedures, Svcs or Supplies (Modifier 4) | A/N | 5 | 42-43 |
| 47 | 24.5e | Diagnosis Pointer | N | 6 | 45-48 |
| 47 | 24.5f | $ Charges | N | 8 | 50-57 |
| 47 | 24.5g | Days or Units | N | 3 | 59-61 |
| 47 | 24.5h | EPSDT Family Plan | A | 1 | 63 |
| 47 | 24.5i | Legacy Qualifier Rendering Provider (Leave Blank) | A/N | 0 | |
| 47 | 24.5j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 48 | 24 | Line Detail Narrative | A/N | 63 | 01-63 |
| 48 | 24.6i | Legacy Qualifier Rendering Provider | A/N | 2 | 65-66 |
| 48 | 24.6j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 49 | 24.6a | Date(s) of Service - (From Month) | N | 2 | 01-02 |
| 49 | 24.6a | Date(s) of Service - (From Day) | N | 2 | 04-05 |

| | | | | | |
|---|---|---|---|---|---|
| 49 | 24.6a | Date(s) of Service - (From Year) | N | 2 | 07-08 |
| 49 | 24.6a | Date(s) of Service - (To Month) | N | 2 | 10-11 |
| 49 | 24.6a | Date(s) of Service - (To Day) | N | 2 | 13-14 |
| 49 | 24.6a | Date(s) of Service - (To Year) | N | 2 | 16-17 |
| 49 | 24.6b | Place of Service | A/N | 2 | 19-20 |
| 49 | 24.6c | EMG | A | 2 | 22-23 |
| 49 | 24.6d | Procedures, Svcs or Supplies (CPT/HCPCS) | A/N | 5 | 25-30 |
| 49 | 24.6d | Procedures, Svcs or Supplies (Modifier 1) | A/N | 2 | 33-34 |
| 49 | 24.6d | Procedures, Svcs or Supplies (Modifier 2) | A/N | 5 | 36-37 |
| 49 | 24.6d | Procedures, Svcs or Supplies (Modifier 3) | A/N | 2 | 39-40 |
| 49 | 24.6d | Procedures, Svcs or Supplies (Modifier 4) | A/N | 5 | 42-43 |
| 49 | 24.6e | Diagnosis Pointer | N | 6 | 45-48 |
| 49 | 24.6f | $ Charges | N | 8 | 50-57 |
| 49 | 24.6g | Days or Units | N | 3 | 59-61 |
| 49 | 24.6h | EPSDT Family Plan | A | 1 | 63 |
| 49 | 24.6i | Legacy Qualifier Rendering Provider (Leave Blank) | A/N | 0 | |
| 49 | 24.6j | Legacy Provider Number Rendering Provider | A/N | 11 | 68-78 |
| 51 | 25 | Federal Tax ID Number | N | 15 | 1-15 |
| 51 | 25 | Federal Tax ID Number (SSN) | M | 1 | 17 |
| 51 | 25 | Federal Tax ID Number (EIN) | M | 1 | 19 |
| 51 | 26 | Patient's Account Number | A/N | 14 | 23-36 |
| 51 | 27 | Accept Assignment (Yes) | M | 1 | 38 |
| 51 | 27 | Accept Assignment (No) | M | 1 | 43 |
| 51 | 28 | Total Charge | N | 9 | 51-59 |
| 51 | 29 | Amount Paid | N | 8 | 62-69 |
| 51 | 30 | Balance Due | N | 8 | 71-78 |
| 52 | 33 | Billing Provider Phone Number Area Code | N | 3 | 66-68 |
| 52 | 33 | Billing Provider Phone Number | N | 9 | 70-78 |
| 53 | 32 | Name of Facility Where Svcs Rendered | A/N | 26 | 23-48 |
| 53 | 33 | Physician/Supplier Billing Name | A/N | 29 | 50-78 |
| 54 | 32 | Address of Facility Where Svcs Rendered | A/N | 26 | 23-48 |
| 54 | 33 | Physician/Supplier Address | A/N | 29 | 50-78 |
| 55 | 31 | Left Blank for Signature Physician/Supplier | | | |
| 55 | 32 | City, State and Zip Code of Facility | A/N | 26 | 23-48 |
| 55 | 33 | City, State and Zip Code of Billing Provider | A/N | 29 | 50-78 |
| 56 | 32a | Facility NPI Number | N | 10 | 24-33 |
| 56 | 32b | Facility Qualifier and Legacy Number | A/N | 14 | 35-48 |
| 56 | 33a | Billing Provider NPI Number | N | 10 | 51-60 |
| 56 | 33b | Billing Provider Qualifier and Legacy Number | A/N | 17 | 62-78 |

* M = mark (X), A = alpha, N = numeric

1500

# TEST VERSION – NOT FOR OFFICIAL USE

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY | STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | NPI | |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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# TEST VERSION – NOT FOR OFFICIAL USE

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY | STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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# TEST VERSION – NOT FOR OFFICIAL USE

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

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

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

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

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION**

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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