# SECTION 2
# CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

Wipro Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

**NOTE:** An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

| **Field number and name** | | **Instructions for completion** |
|---|---|---|
| 1. | Type of Health Insurance Coverage | Show the type of health insurance coverage applicable to this claim by checking the appropriate box. |
| 1a.* | Insured's I.D. | Enter the patient's eight-digit MO HealthNet ID number (DCN) as shown on the patient's ID card. |
| 2.* | Patient's Name | Enter last name, first name, middle initial *in this order* as it appears on the patient's ID card. |
| 3. | Patient's Birth Date<br>Sex | Enter month, day, and year of birth.<br>Mark appropriate box. |
| 4.** | Insured's Name | If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank. |
| 5. | Patient's Address | Enter address and telephone number if available. |

| Field number and name | Instructions for completion |
|---|---|
| 6.** Patient Relationship to Insured | Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank. |
| 7.** Insured's Address | Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank. |
| 8. Patient Status | Not required. |
| 9.** Other Insured's Name | If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. [See Note (1)] |
| 9a.** Other Insured's Policy or Group Number | Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)] |
| 9b.** Other Insured's Date of Birth | Enter the secondary policyholder's date of birth and mark the appropriate box for the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)] |
| 9c.** Employer's Name | Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)] |
| 9d.** Insurance Plan Name or Program Name. | Enter the secondary policyholder's insurance plan or program name. If no private insurance is involved, leave blank.<br>*If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)] |
| 10a.-10c.** Is Patient's Condition Related to: | If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. **If the services are not related to an accident, leave blank.** [See Note (1)] |

| **Field number and name** | **Instructions for completion** |
|---|---|
| 10d. Reserved for Local Use | May be used for comments/descriptions. |
| 11.** Insured's Policy or FECA Number | Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)] |
| 11a.** Insured's Date of Birth | Enter primary policyholder's date of birth and mark the appropriate box for the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)] |
| 11b.** Employer's Name | Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)] |
| 11c.** Insurance Plan Name or Program Name | Enter the primary policyholder's insurance plan name.<br>*If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)] |
| 11d.** Other Health Plan | Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. If no private insurance is involved, leave blank. [See Note (1)] |
| 12. Patient's Signature | Leave blank. |
| 13. Insured's Signature | This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder. |

| Field number and name | Instructions for completion |
|---|---|
| 14.** Date of Current Illness, Injury or Pregnancy | *This field is required when billing global prenatal, global OB and delivery services*. The date should reflect the last menstrual period (LMP). |
| 15. Date Same/Similar Illness | Leave blank. |
| 16. Dates Patient Unable to Work | Leave blank. |
| 17.** Name of Referring Provider or Other Source | Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1) referring provider; 2) ordering provider; or, 3) supervising provider.<br>If the physician is nonparticipating in the MO HealthNet program, enter "nonparticipating."<br>*This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).* |
| 17a.** Other ID | Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in 17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in 17b.<br>*This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).* |
| 17b.** NPI | Enter the NPI number of the referring, ordering or supervising provider<br>*This field is required for independent laboratories and independent radiology groups and providers with a specialty of "30" (radiology/radiation therapy).* |

| Field number and name | Instructions for completion |
|---|---|
| 18.** Hospitalization Dates | If the services on the claim were provided in an inpatient hospital setting, enter the admit date.<br>This field is required if services were provided in an inpatient hospital setting. |
| 19. Reserved for Local Use | Providers may use this field for additional remarks/descriptions. |
| 20.** Lab Work Performed Outside Office | If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out. |
| 21.* Diagnosis | Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc. |
| 22.** MO HealthNet Resubmission | For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely. |
| 23. Prior Authorization Number | Leave blank**.** |
| 24a.* Date of Service | Enter the date of service under “from” in the month/day/year format using the six digit format in the unshaded area of the field. All line items must have a from date. A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.<br>The six service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines is shaded and is the location for reporting supplemental information. It is **not** intended to allow the billing of 12 lines of service. |

| **Field number and name** | **Instructions for completion** |
|---|---|
| 24b.* Place of Service | Enter the appropriate place of service code in the unshaded area of the field. See Section 15.8 of the MO HealthNet *Physician's Provider Manual* for the list of appropriate place of service codes. Place of service for local health departments is "71" when services are provided in the agency's facility/clinic. |
| 24c. EMG-Emergency | Enter a Y in the unshaded area of the field. If this is not an emergency, leave this field blank. |
| 24d.* Procedure Code | Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.) |
| 24e.* Diagnosis Pointer | Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21 in the unshaded area of the field. |
| 24f.* Charges | Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown. |
| 24g.* Days or Units | Enter the number of days or units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1" if the field is left blank.<br>Anesthesia—Enter the total number of minutes of anesthesia.<br>Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a. |
| 24h.** EPSDT/Family Planning | If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "F." If the service is both an EPSDT/HCY and Family Planning service enter "B." |

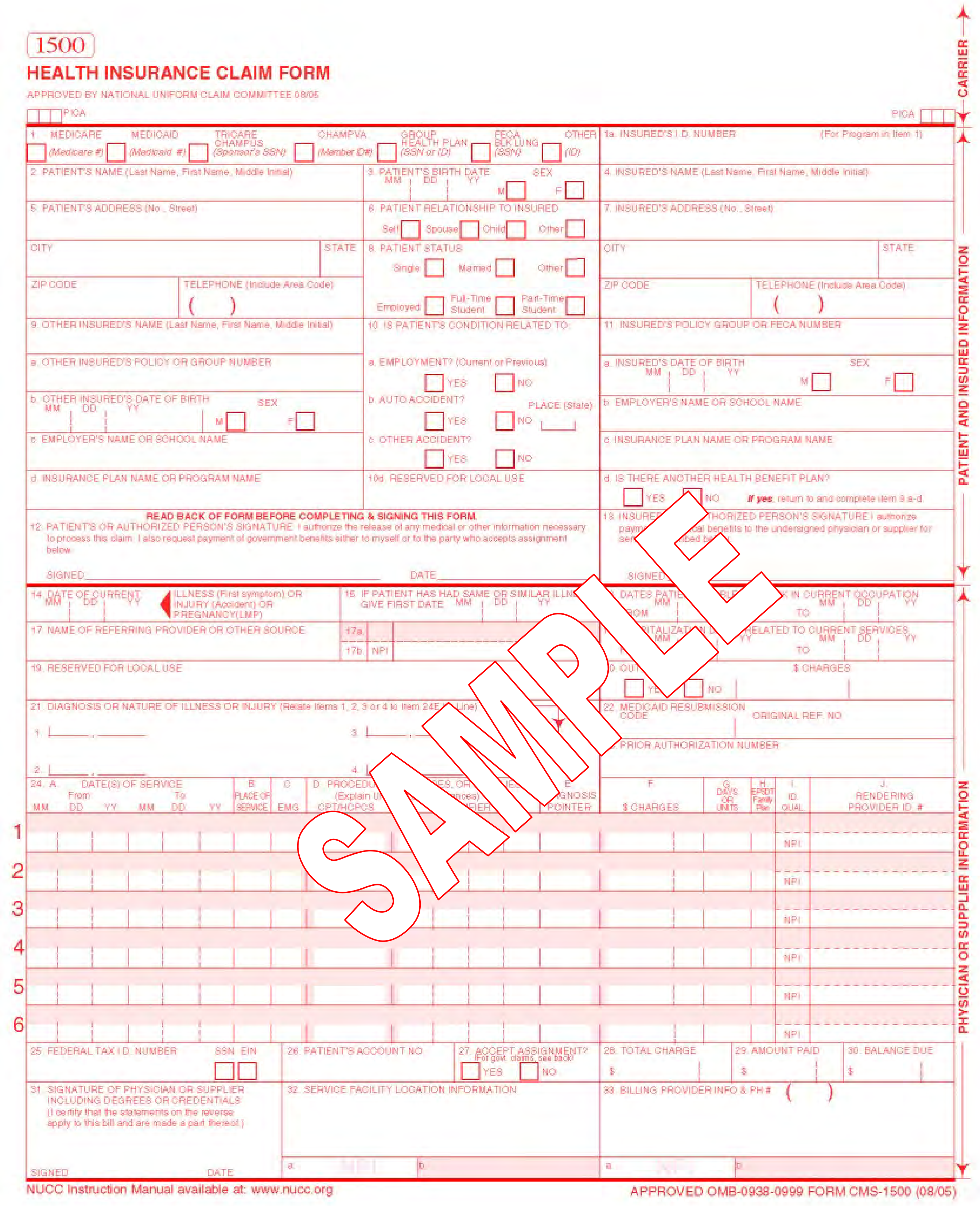
| **Field number and name** | **Instructions for completion** |
|---|---|
| 24i. ID Qualifier | Enter the Provider Taxonomy qualifier ZZ in the shaded area if the health department's rendering/performing provider is required to report a Provider Taxonomy Code to MO HealthNet. |
| 24j.** Rendering Provider ID | If the Provider Taxonomy qualifier was reported in 24i, enter the 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering/performing the service in the unshaded area.<br>This should be the NPI of the health department's nurse practioner or supervising physician. |
| 25. SS#/Fed. Tax ID | Leave blank. |
| 26. Patient Account Number | For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here. |
| 27. Assignment | Not required on MO HealthNet claims. |
| 28.* Total Charge | Enter the sum of the line item charges. |
| 29.** Amount Paid | Enter the total amount received by all other insurance resources. **Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.** |
| 30. Balance Due | Enter the difference between the total charge (field 28) and any insurance amount paid (field 29). |
| 31. Provider Signature | Leave blank. |
| 32.** Name and Address of Facility | If the services were rendered in a facility other than the home or health department clinic, enter the name and location of the facility. |

| **Field number and name** | **Instructions for completion** |
|---|---|
| 32.** Name and Address of Facility (cont.) | This field is required when the place of service is other than the home or the health department clinic. |
| 32a.** NPI Number | Enter the 10 digit NPI number of the service facility location reported in field 32. |
| 32b.** Other ID Number | Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number. |
| 33.*Provider Name/ Number/ Address | Enter the health department's name, address, and telephone number. |
| 33a.* NPI Number | Enter the health department's NPI number. |
| 33b.** Other ID Number | Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 33a if the health department is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and the number. |

* These fields are mandatory on all CMS-1500 claim forms.

** These fields are mandatory only in specific situations as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **leave blank**. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet *Provider's Manual* for further TPL (Third Party Liability) information.



1500

**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. INSURE THORIZED PERSON'S SIGNATURE I authorize paym cal benefits to the undersigned physician or supplier for ser ibed be

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 ILLN GIVE FIRST DATE MM DD YY

DATES PATIE RI K IN CURRENT OCCUPATION MM DD YY ROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

ITALIZATI N D RELATED TO CURRENT SERVICES MM YY MM DD YY TO

19. RESERVED FOR LOCAL USE

0. OUT ☐ YE ☐ NO $ CHARGES

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

1. . 3. .

2. . 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDU (Explain U CPT/HCPCS ES, OR nces) IER | E. GNOSIS 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.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

SAMPLE
CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION