SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 (08-05) 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.
> PO 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 indicates 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 participant's ID card.
2.*Patient's Name	Enter last name, first name, middle initial in that order as it appears on the ID card.
3.Patient's Birth Date, Sex	Enter month, day, and year of birth. 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.
5.Patient's Address	Enter address and telephone number if available.
6.Patient's Relationship To Insured	Mark appropriate box if there is other insurance.
7.Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available.
8.Patient Status	Not used.

9.**Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. See Note(1)
9a.**Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance Group Number policy number or group number, if the insurance is through a group such as an employer, union, etc. See Note(1)
9b.**Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. See Note(1)
9c.**Employer's Name	Enter the secondary policyholder's employer name. See Note(1)
9d.**Insurance Plan Or Program Name	Enter the other insured's insurance plan program name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. See Note(1)
10a.-10c. Is 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.
10d. Reserved for Local Use	May be used for comments/descriptions.
11.**Insured's Policy or Group 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. See Note(1)
11a.** Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. See Note(1)
11b.**Employer's Name	Enter the primary policyholder's employer name. See Note(1)
11c.**Insurance Plan Name	Enter the primary policyholder's insurance plan name. 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. See Note(1)

12.Participant'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.
14.Date of Current Illness, Injury	Not required for Ambulance
15.Date Same/Similar Illness	Leave blank.
16.Dates Patient Unable To Work	Leave blank.
17.Name of Referring Physician	Not required for Ambulance
17a.Other I.D.	Not required for Ambulance
17b.NPI	Not required for Ambulance
18.Hospitalization Dates	Not required for Ambulance
19.Reserved for Local Use	Providers may use this field for additional remarks or descriptions.
20.Lab Work Performed Outside Office	Not required for Ambulance
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 month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a "from" date.
24b.*Place of Service	Enter the appropriate place of service code. Place of service is the destination of the ambulance trip.
24c.**EMG-Emergency	Enter a Y in the unshaded area of the field if this is an emergency. If this is not an emergency leave this field blank.
24d.*Procedure Code	Enter the appropriate HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (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 the field. The system automatically plugs a “1” if the field is left blank. Units shown must reflect the total “loaded” mileage one-way from point of pick-up to destination.
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY transport, enter “E.”
24i.ID Qualifier	Leave blank.
24j.Rendering Provider ID	Not required for ambulance.
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 the insurance amount paid (field 29).
31.Provider Signature	Leave blank.
32.**Name and Address of Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
32a.**NPI#	Enter the 10-digit NPI number of the service facility location in 32.
32b.Other ID#	Leave blank.
33.*Provider Name/ Number/Address	Write or type the information exactly as it appears in the Provider Master file.
33a.* NPI #	Enter the NPI number of the billing provider in 33.
33b. Other ID #	Leave blank.