

## PROVIDER BULLETIN

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# CMS-1500 (02-12) HEALTH INSURANCE CLAIM FORM

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## CMS-1500 (02-12) HEALTH INSURANCE CLAIM FORM

As mandated by the National Uniform Claim Committee (NUCC), providers who submit paper claim forms to the MO HealthNet Division (MHD) will be required to use the new CMS-1500 (02-12) Health Insurance Claim Form. Although the CMS-1500 form (02-12) is effective January 6, 2014, use of the revised form is optional until March 31, 2014. The transitional dual acceptability period of the current and the revised forms is described as follows:

- January 6, 2014 – March 31, 2014: Providers can use either the current CMS-1500 form (08-05) version or the revised CMS-1500 form (02-12) version.
- April 1, 2014: The current CMS-1500 form (08-05) version is discontinued; only the revised CMS-1500 form (02-12) version is to be used.

All rebilling of claims must use the revised CMS-1500 form (02-12) version from April 1, 2014 and forward, even though earlier submissions may have been submitted on the prior CMS-1500 form (08-05) version.

The revised form accommodates reporting needs for ICD-10, as announced in the October 16, 2013 provider information bulletin, Volume 36, No.10, which may be accessed at: [http://dss.mo.gov/mhd/providers/pdf/bulletin36-10\\_2013oct16.pdf](http://dss.mo.gov/mhd/providers/pdf/bulletin36-10_2013oct16.pdf). The new claim form also aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3. Work was done to better align the 1500 Claim Form with the ASC X12 837P transaction, which means that several fields on the paper form were removed because they are not reported in the electronic transaction.

## BILLING INSTRUCTIONS

The fields being changed that are currently used by MHD are listed below.

- Field 9c, which was previously entitled Employer's Name or School Name is now entitled Reserved for NUCC use.
- Field 10d, which was previously entitled Reserved for Local Use is now entitled Claim Codes (NUCC).
- Field 11b, which was previously entitled Employer's Name or School Name is now entitled Other Claim ID.

- Field 21, which was previously entitled Diagnosis Code 1-4 is now Diagnosis Code A-L, has an indicator for ICD-9 or ICD-10, which is not used by MHD and has added 8 additional lines for diagnosis codes.

Instructions for completing the standard CMS-1500 (02-12) Health Insurance Claim Form are listed below.

<b>Field Number &amp; Name</b>	<b>Requirements</b>	<b>Instructions for Completion</b>
1. Type of Health Insurance Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed check the Medicare box, if a MO HealthNet claim is being filed check the MO HealthNet box and if the patient has both Medicare and MO HealthNet, check both boxes.
1a. Insured's I.D. Number	Required	Enter the patient's eight-digit MO HealthNet number (DCN) as shown on the patient's ID card.
2. Patient's Name	Required	Enter last name, first name, middle initial in that order as it appears on the ID card.
3. Patient's Birth Date, Sex	Optional	Enter month, day, and year of birth, mark appropriate box.
4. Insured's Name	Required when applicable	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	Optional	Enter address and telephone number if available.
6. Patient's Relationship to Insured	Required when applicable	Mark appropriate box if there is other insurance.
7. Insured's Address	Required when applicable	Enter the primary policyholder's address; enter policyholder's telephone number, if available.
8. Reserved for NUCC Use	Not Used	Leave Blank.
9 Other Insured's Name	Required when applicable	Enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2.
9a. Other Insured's Policy or Group Number	Required when applicable	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc.  NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.

9b. Reserved for NUCC Use	Not Used	Leave Blank.
9c. Reserved for NUCC Use	Not Used	Leave Blank.
9d. Insurance Plan Name or Program Name	Required when applicable	<p>Enter the other insured's insurance plan or program name.</p> <p>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.</p> <p>NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.</p>
10a.-10c. Is Condition Related to:	Required when applicable	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank.
10d. Claim Codes (Designated by NUCC)	Not Used	Leave Blank.
11. Insured's Group Policy or FECA Number	Required when applicable	<p>Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc.</p> <p>NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.</p>
11a. Insured's Date of Birth, Sex	Required when applicable	<p>Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder.</p> <p>NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.</p>
11b. Other Claim ID (Designated by NUCC)	Required when applicable	Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
11c. Insurance Plan Name or Program Name	Required when applicable	<p>Enter the primary policyholder's insurance plan name.</p> <p>If the insurance plan denied payment for the service provided, attach a valid denial from the</p>

		insurance plan.  NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
11d. Other Health Benefit Plan	Required when applicable	Indicate whether the patient has a secondary health insurance plan; if so, complete Fields 9, 9a and 9d with the secondary insurance information.  NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employer's name or other information appears in this field, the claim will deny.
12. Patient's or Authorized Person's Signature	Not Used	Leave blank.
13. Insured's or Authorized Person's Signature	Required when applicable	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 or Pregnancy	Required when applicable Not required for: Ambulance, Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy.	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15. Other Date	Not Used	Leave blank.
16. Dates Patient Unable to Work	Not Used	Leave blank.
17. Name of Referring Provider or Other Source	Required when applicable  Required for independent laboratory and radiology	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 3. Supervising Provider

	<p>providers and physicians with a specialty of radiology/radiation therapy.</p> <p>Not required for: Ambulance, DME, Optical or Rehabilitation Centers</p>	
17a. Other ID #	<p>Required when applicable</p> <p>Required for independent laboratory and radiology providers and physicians with a specialty of radiology/radiation therapy.</p> <p>Not required for: Ambulance, DME, Optical or Rehabilitation Centers</p>	<p>The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.</p> <p>The NUCC defines the following qualifiers used in 5010A1:</p> <p>0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.)</p>
17b. NPI	<p>Required when applicable</p> <p>Not required for: Ambulance, DME, Optical or Rehabilitation Centers</p>	<p>Enter the NPI number of the referring, ordering, or supervising provider.</p>
18. Hospitalization Dates	<p>Required when applicable</p> <p>Not required for: Ambulance, Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy</p>	<p>If the services on the claim were provided in an inpatient hospital setting, enter the admit date. This field is required when the service is performed on an inpatient basis.</p>

19. Additional Claim Information (Designated by NUCC)	Optional	Providers may use this field for additional remarks/descriptions. <b>Rehabilitation Centers and Therapy:</b> Enter the amount of time spent by the therapist in fabricating/applying cast/splint.
20. Outside Lab	Required when applicable  Not required for: Ambulance, Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy.	If billing for laboratory charges, mark appropriate box. The referring physician may not bill for lab work that was referred out.
21. Diagnosis	Required	Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Enter the diagnosis in the same order on all pages of claims with multiple lines. The ICD indicator is not used.
22. Resubmission Code	Required when applicable	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	Not Used	Leave blank.
24A. Date(s) of Service	Required	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. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.  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 are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

		<p><b>Hearing Aid and Optical:</b> A "to" date of services is not used. The date of service for frames, lenses, and hearing aids and related services must be the date the items were dispensed.</p> <p><b>Therapy and Rehabilitation Centers:</b> A "to" date of service is not required.</p> <p><b>DME:</b> A "from" and "to" date is required when billing for DME rental.</p>
24B. Place of Service	Required	<p>Enter the appropriate place of service code in the unshaded area of the field:</p> <p><b>Ambulance:</b> Place of service is the destination of the ambulance trip.</p>
24C. EMG-Emergency	<p>Required when applicable</p> <p>Not required for: Comprehensive Day Rehab, Environmental Lead, Hearing Aid, Optical, Rehabilitation Centers or Therapy.</p>	<p>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.</p>
24D. Procedure Code	Required	<p>Enter the appropriate CPT or 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.)</p>
24E. Diagnosis Pointer	Required	<p>Enter A, B, C, D or the actual diagnosis code(s) from Field #21 in the unshaded area of the field.</p>
24F. Charges	Required	<p>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.</p> <p><b>Optical and Hearing Aid:</b> Do not subtract the copay amount from the charge.</p>
24G. Days or Units	Required	<p>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.</p> <p><b>Ambulance:</b> Units shown must reflect the total "loaded" mileage one-way from point of pick-up to destination.</p>

		<p><b>Anesthesia:</b> Enter the total number of minutes of anesthesia.</p> <p><b>Consecutive visits</b>—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.</p> <p><b>DME:</b> DME rental equipment under the regular DME program, the “from” and “to” dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity must always be a “1”. When billing ostomy supplies under procedure code A4421, the quantity is always a “1”.</p> <p><b>Injections:</b> Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is “2.”</p>
24H. EPSDT/Family Planning	Required when applicable	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 enter “B”.
24L. ID Qualifier	Required when applicable	Enter in the shaded area of 24L the qualifier identifying if the number is a non-NPI. The other ID number of the rendering provider should be reported in 24J in the shaded area.
24J. Rendering Provider ID	Required when applicable Not Required for: Ambulance	<p>The individual rendering the service is reported in this field.</p> <p>Enter the NPI number of the provider in the unshaded area of the field.</p> <p>This field is required for a clinic, radiology, teaching institution, or a group practice only.</p>
25. Federal Tax ID Number	Not Used	Leave blank.
26. Patient Account Number	Optional	For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.

27. Accept Assignment	Not Used	Leave Blank.
28. Total Charge	Required	Enter the sum of the line item charges.
29. Amount Paid	Optional	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are not to be entered in this field.
30. Reserved for NUCC Use	Not Used	Leave Blank.
31. Provider Signature	Not Used	Leave Blank.
32. Service Facility Location Information	Required when applicable	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 #	Required when applicable	Enter the NPI number of the service facility location in 32.
32b. Other ID#	Required when applicable	Enter number.
33. Provider Name/ Number/Address	Required	Affix the billing provider label or write or type the information exactly as it appears on the label.
33a. NPI #	Required when applicable	Enter the NPI number of the billing provider in 33.
33b. Other ID #	Required when applicable	Enter number.

Please refer to the NUCC web site (<http://www.nucc.org/>) for more information on the new CMS-1500 (02-12) Health Insurance Claim Form, to review claim filing instructions, obtain a 1500-837P crosswalk, etc.

**Provider Bulletins** are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

**MO HealthNet News:** Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

**MO HealthNet Managed Care:** The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

**Provider Communications Hotline  
573-751-2896**