PPN Instructions for Completing the CMS 1500 Claim Form

The form 1500 must be used to bill for services. Please note that each claim form is for only one rendering provider. If there are multiple providers, each provider must complete a separate form. All items must be completed unless otherwise noted in these instructions. The 1500 field descriptions and instructions are included below.

<table>
<thead>
<tr>
<th>CMS 1500 Field Location</th>
<th>Required Field?</th>
<th>Description and Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Required</td>
<td>Client’s BHRS assigned ID number or SSN or CIN number when billing services</td>
</tr>
<tr>
<td>2</td>
<td>Required</td>
<td>Patient’s Name</td>
</tr>
<tr>
<td>3</td>
<td>Required</td>
<td>Patient’s Birth date – Enter member’s date of birth and check the box for male or female.</td>
</tr>
<tr>
<td>5</td>
<td>Required</td>
<td>Patient’s Address – Enter member’s complete address and telephone number.</td>
</tr>
<tr>
<td>6</td>
<td>If Applicable</td>
<td>Patient’s Relationship to Insured – Only Self or Child is applicable.</td>
</tr>
<tr>
<td>12</td>
<td>Required</td>
<td>Enter “Signature on File” and Date</td>
</tr>
<tr>
<td>13</td>
<td>Required</td>
<td>Enter “Signature on File” and Date</td>
</tr>
<tr>
<td>21</td>
<td>Required</td>
<td>Diagnosis – Enter all letters and/or numbers of the ICD-10-CM code for each diagnosis, including fourth and fifth digits if present. The first diagnosis listed in section 21.1 indicates the primary reason for the service provided</td>
</tr>
<tr>
<td>23</td>
<td>Required</td>
<td>Enter authorization number</td>
</tr>
<tr>
<td>24A</td>
<td>Required</td>
<td>Dates of Service – Enter the date the service was rendered in the “from” and “to” boxes in the MMDDYY format. If services were provided on only one date, indicated only in the “from” column. If the services were provided on multiple dates (i.e., DME rental, hemodialysis management, radiation therapy, etc), the range of dates and number of services should be indicated. “To” date should never be greater than the date the claim is received by the Health Plan.</td>
</tr>
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<td>Description and Requirements</td>
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<td>-----------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>24D</td>
<td>Required</td>
<td>Procedure or cpt code – Enter the duration of the service in the modifier column. NOTE: the duration must match the duration on the progress note.</td>
</tr>
<tr>
<td>24F</td>
<td>Required</td>
<td>Charges – Enter the charge for service in dollar amount format.</td>
</tr>
<tr>
<td>24G</td>
<td>Required</td>
<td>Units – Enter the number units.</td>
</tr>
<tr>
<td>24J</td>
<td>Required</td>
<td>Rendering Provider ID #/ NPI – Enter the Rendering Provider's NPI number</td>
</tr>
<tr>
<td>25</td>
<td>Required</td>
<td>Federal Tax ID Number – Enter the Federal Tax ID for the billing provider.</td>
</tr>
<tr>
<td>28</td>
<td>Required</td>
<td>Total Charge – Enter the total for all services in dollar and cents. Do not include decimals. Do not leave blank.</td>
</tr>
<tr>
<td>31</td>
<td>Required</td>
<td>Name of rendering provider – This should match with box 24J</td>
</tr>
<tr>
<td>32</td>
<td>Required</td>
<td>Service Facility Location Information – this should match box 33</td>
</tr>
<tr>
<td>32a</td>
<td>Required</td>
<td>Service Facility Location Information – Enter the NPI of the facility where the services were rendered.</td>
</tr>
<tr>
<td>33</td>
<td>Required</td>
<td>Should match box 32</td>
</tr>
<tr>
<td>33a</td>
<td>Required</td>
<td>Should match 32a</td>
</tr>
</tbody>
</table>

Updated August 2017
### HEALTH INSURANCE CLAIM FORM

**Approved by National Uniform Claim Committee 08/05**

#### 1. MEDICARE
- Medicare #: [Medicare #]
- Medicare #: [Medicare #]

#### 2. PATIENT'S NAME (Last Name, Middle Name, First Name)
- Client Last Name, First Name

#### 3. PATIENT'S BIRTH DATE

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

#### 5. PATIENT'S ADDRESS (No., Street)
- 225 37TH AVE.

#### 6. PATIENT'S RELATIONSHIP TO INSURED
- Self □ Spouse □ Child □ Other □

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

#### 8. PATIENT STATUS
- Single □ Married □ Other □

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

#### 10. IS PATIENT'S CONDITION RELATED TO:
- EMPLOYMENT? (Current or Previous) □ YES □ NO
- AUTO ACCIDENT? □ YES □ NO
- OTHER ACCIDENT? □ YES □ NO

#### 11. INSURED'S POLICY GROUP OR FECA NUMBER

#### 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 authorize payment of government benefits to either myself or to the party who accepts assignment below.

#### 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
- Yes □ No □

#### 14. DATE OF CURRENT ILLNESS OR INJURY (Specify Location and Date)
- MM: 01, DD: 10, YYYY: 2016

#### 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
- MM: 01, DD: 10, YYYY: 2016

#### 16. DATES PATIENT WAS NOT WORKING IN CURRENT OCCUPATION

#### 17. NAME OF REFERENCING PROVIDER OR OTHER SOURCE
- NPI: 90834

#### 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

#### 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
- DSM5/CD10 CODES

#### 22. MEDICAID RESUBMISSION CODE
- ORIGINAL REF. NO.

#### 23. PRIOR AUTHORIZATION NUMBER

#### 24. DATES OF SERVICE

#### 25. PLACE OF SERVICE
- ENG

#### 26. PATIENT'S ACCOUNT NO.

#### 27. ACCEPT ASSIGNMENT?
- YES □ NO □

#### 28. TOTAL CHARGE
- $58,000

#### 29. AMOUNT PAID

#### 30. BALANCE DUE

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**Signature on File**

**Signature**

**Date**

NPI Number

Therapist Name

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**Facility Information**

**Facility Location**

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**Billing Information**

**Agency Name**

**Address, City, Zip Code**

**Phone Number**

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**NNUC Instruction Manual available at www.nucc.org**

**WCMS-1500CS**

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