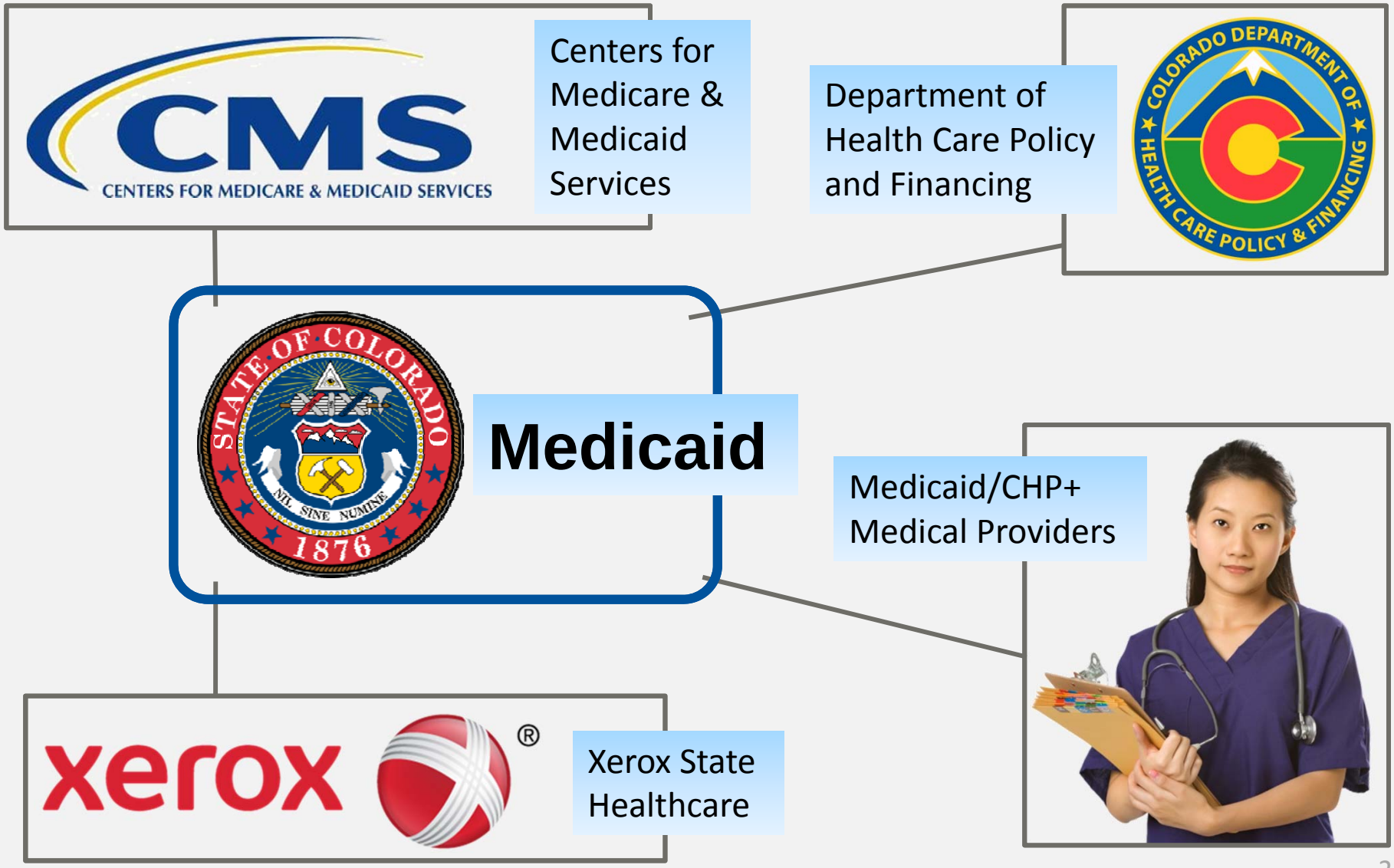
Beginning Billing Workshop CMS 1500

Colorado Medicaid
2015


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Centers for Medicare & Medicaid Services
Department of Health Care Policy and Financing
COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING
STATE OF COLORADO
NIL SINE NUMINE
1876
Medicaid
Medicaid/CHP+ Medical Providers
xerox
Xerox State Healthcare

Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - How to ensure your claims are timely
  - When to use the CMS 1500 paper claim form
  - How to bill when other payers are involved

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

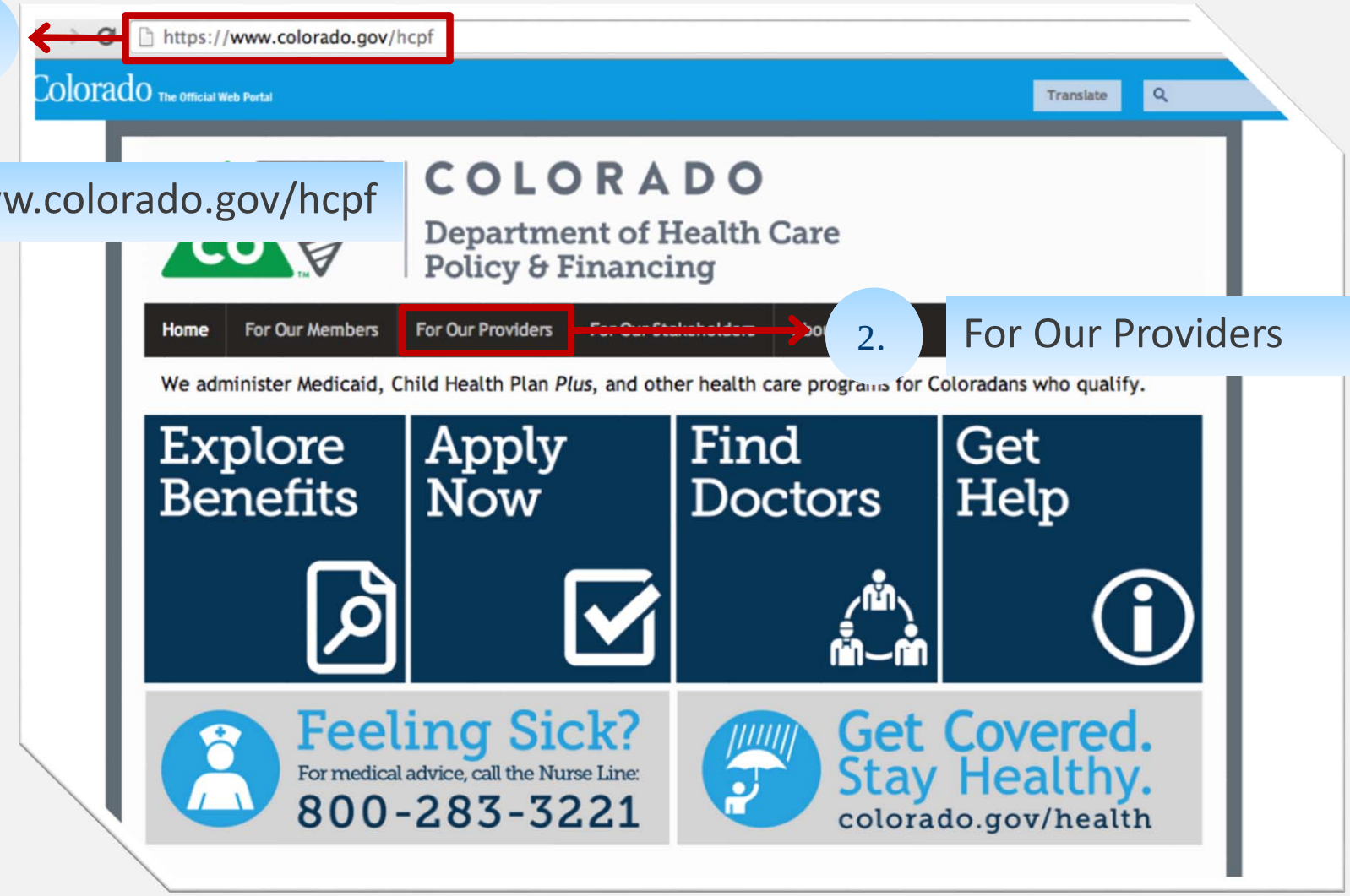
What is an NPI?

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

NEW! Department Website

1.

www.colorado.gov/hcpf



2. For Our Providers

NEW! Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

The Official Web Portal

Translate

COLORADO
Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers | For Our Stakeholders | About Us

For Our Providers

hy should u become provider?

How to become a provider (enroll)

Provider services (training, & more)

What's new? (bulletins, newsletters, updates)

Get Help
Dept. Fiscal Agent
1-800-237-0757

Get Info
FAQs & More

Find a Doctor
Are you a client looking for a doctor?

Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls providers into the Colorado Medical Assistance Program, *not* members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Rendering Versus Billing

Rendering Provider

- Individual that provides services to a Medicaid member

Billing Provider

- Entity being reimbursed for service

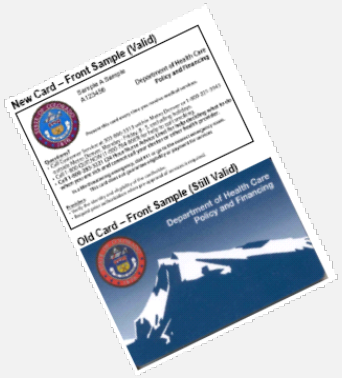
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Web Portal

Fax Back
1-800-493-0920

CMERS/AVRS
1-800-237-0757



Medicaid ID Card with Switch Vendor

Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number

Eligibility Request Response (271)

Print

Return To Eligibility Inquiry

Eligibility Request

Provider ID:

From DOS:

Client Detail

State ID:

Last Name:

CO MEDICAL ASSISTAN

Response Creation Date & Time: 05/

Contact Information for Questions or

Provider Relations Number: 800-237

Requesting Provider

Provider ID:

Name:

Client Details

Name:

State ID:

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Messages:

MHPROV Services

Provider Name:

COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number:
800-804-5008

Information appears in sections:

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use the scroll bar to the right to view more details

Successful inquiry notes a Guarantee Number:

- Print a copy of the response for the member's file when necessary

Reminder:

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility

Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Eligibility Types

- Most members= Regular Colorado Medicaid benefits
- Some members= different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members= additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance

Eligibility Types

Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services

Eligibility Types

Non-Citizens

- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

What Defines an "Emergency"?

- **Sudden**, **urgent**, usually **unexpected** occurrence or occasion requiring immediate action such that of:
  - Active labor & delivery
  - Acute symptoms of sufficient severity & severe pain-
    - Severe pain in which, the absence of immediate medical attention might result in:
      - Placing health in serious jeopardy
      - Serious impairment to bodily functions
      - Dysfunction of any bodily organ or part

Eligibility Types

Presumptive Eligibility

- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

Presumptive Eligibility

Presumptive Eligibility

- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
    - Colorado Access- 1-888-214-1101

Managed Care Options

- Types of Managed Care options:
  - Managed Care Organizations (MCOs)
  - Behavioral Health Organization (BHO)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Accountable Care Collaborative (ACC)

Managed Care Options

Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out

Managed Care Options

Behavioral Health Organization (BHO)

- Community Mental Health Services Program
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider

Managed Care Options

Accountable Care Collaborative (ACC)

- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
- Helps coordinate Member care
  - Helps with care transitions

Medicare

Medicare

- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as "Dual Eligible"
- Medicaid is always **payer of last resort**
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - **Submission to Medicare prior to** Colorado Medical Assistance Program
  - Medicare denials(s) for **six years**

Third Party Liability

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)
  - Example:
    - Charge = $500
    - Program allowable = $400
    - TPL payment = $300
    - Program allowable – TPL payment = LOP

	$400.00
-	$300.00
=	$100.00

Commercial Insurance

Commercial Insurance

- Colorado Medicaid always payor of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party's insurance

Co-Payment Exempt Members

Nursing Facility Residents

Children

Pregnant Women

Image courtesy of FreeDigitalPhotos.net & David Castillo Dominici

Co-Payment Facts

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- Collect from member at time of service
- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS
  - Transportation
  - Emergency Services
  - Family Planning Services

Specialty Co-payments

Practitioner Optometrist Speech Therapy RHC / FQHC	**$2.00**
DME / Supply	**$1.00 per date of service**
Outpatient	**$3.00**
Inpatient	**$10.00 per covered day or 50% of the average allowable daily rate- whichever is less**
Psych Services	**.50 per unit of service, 1 unit = 15 minutes**

Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing

Record Retention

- Providers must:
  - Maintain records for at least 6 years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

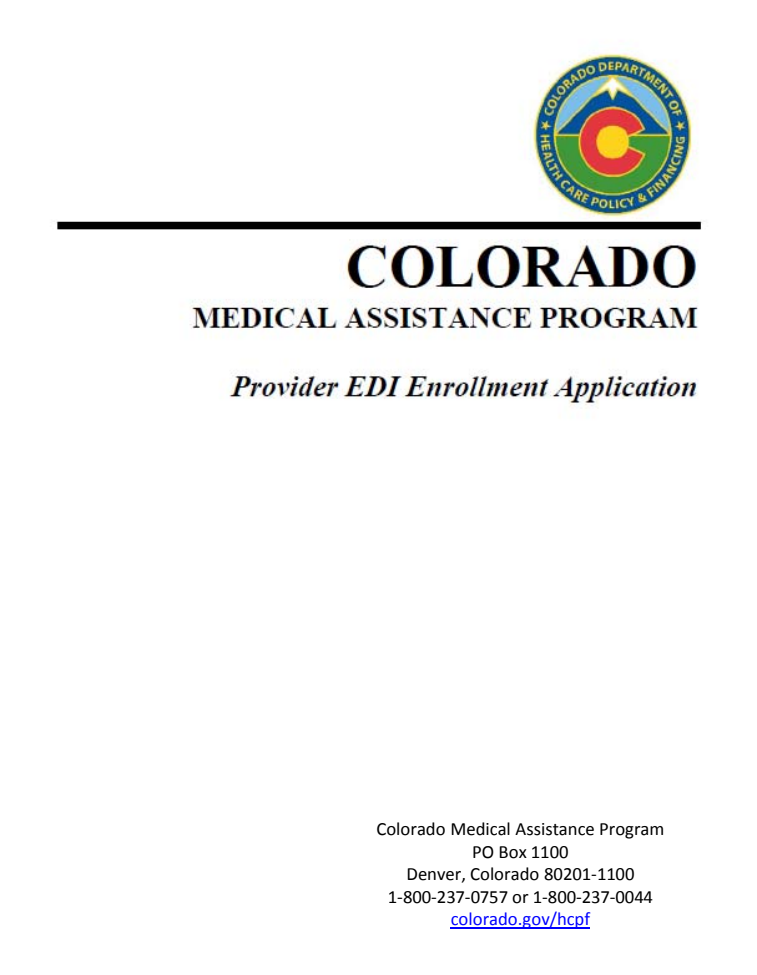
Submitting Claims

- Methods to submit:
  - Electronically through **Web Portal**
  - Electronically using **Batch Vendor**, **Clearinghouse**, or **Billing Agent**
  - **Paper** only when
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

ICD-10 Implementation Delay

- ICD-10 Implementation delayed until 10/1/2015
  - ICD-9 codes: Claims with Dates of Service (DOS) on or before 9/30/15
  - ICD-10 codes: Claims with DOS 10/1/2015 or after
  - Claims submitted with both ICD-9 and ICD-10 codes will be rejected

Providers Not Enrolled with EDI



COLORADO

MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

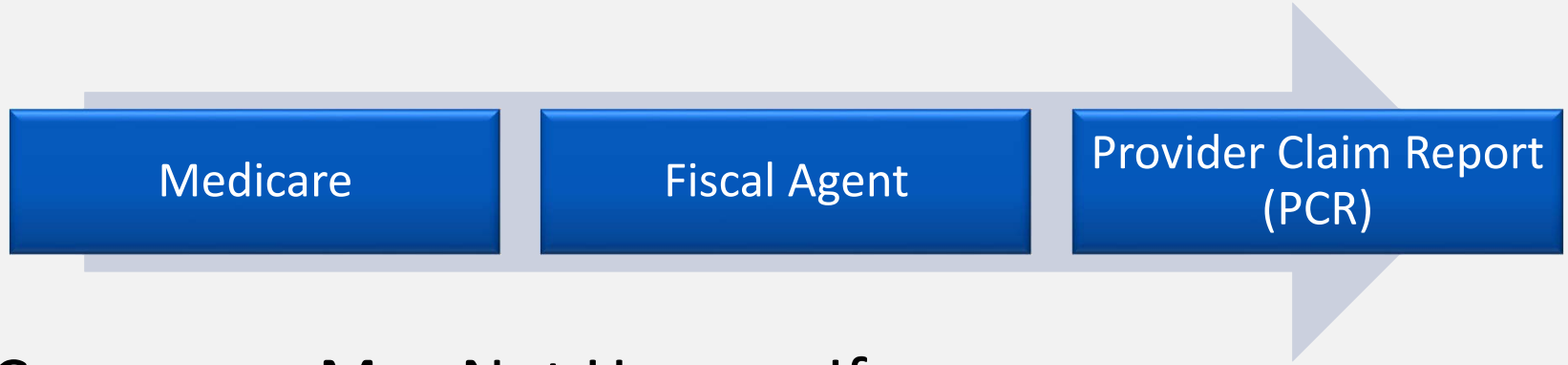
Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757 or 1-800-237-0044
colorado.gov/hcpf

Providers must be enrolled with EDI to use the Web Portal to submit HIPAA compliant claims, make inquiries and retrieve reports electronically

- Select Provider Application for EDI Enrollment
  - Colorado.gov/hcpf → Providers →EDI Support

Crossover Claims

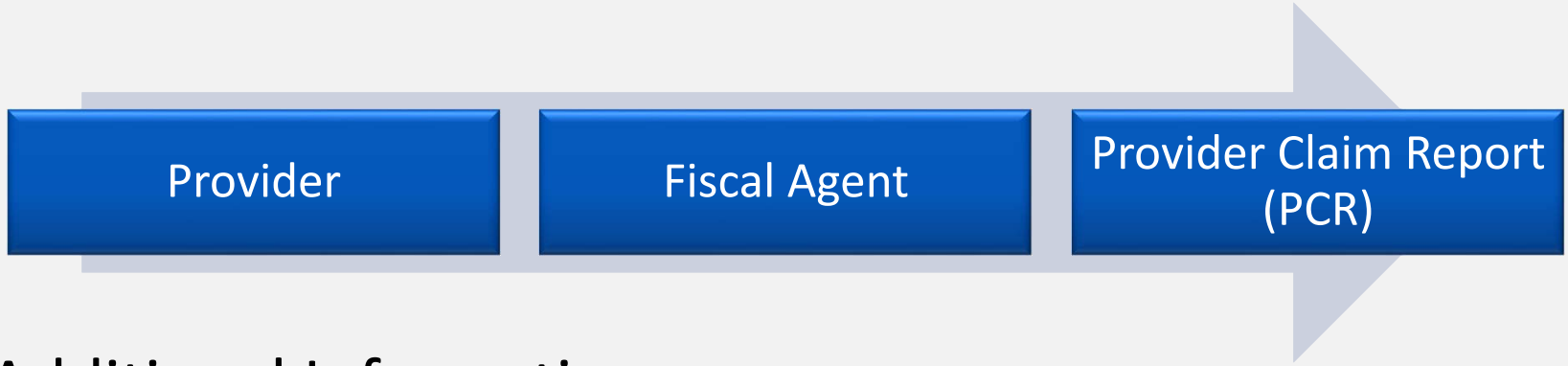
- Automatic Medicare Crossover Process:



- Crossovers May Not Happen If:
  - NPI not linked
  - Member is a retired railroad employee
  - Member has incorrect Medicare number on file

Crossover Claims

- Provider Submitted Crossover Process:



- Additional Information:
  - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - Crossovers may be submitted on paper or electronically
  - Providers must submit copy of SPR with paper claims
  - Provider must retain SPR for audit purposes

Payment Processing Schedule

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Payment information is transmitted to the State's financial system

Accounting processes **E**lectronic **F**unds **T**ransfers (EFT) & checks

EFT payments deposited to provider accounts

Paper remittance statements & checks dropped in outgoing mail

Weekly claim submission cutoff

Fiscal Agent processes submitted claims & creates PCR

Electronic Funds Transfer (EFT)

- Several Advantages:
  - Free!
  - No postal service delays
  - Automatic deposits every Thursday
  - Safest, fastest & easiest way to receive payments
  - Located in Provider Services Forms section on Department website

PARs Reviewed by ColoradoPAR

- With the <u>exception of Waiver and Nursing Facilities:</u>
  - ➢ ColoradoPAR processes all PARs including revisions
  - ➢ Visit coloradopar.com for more information

<u>Mail</u>:
Prior Authorization Request
55 N Robinson Ave., Suite 600
Oklahoma City, OK 73102

<u>Phone</u>:
1.888.454.7686
<u>FAX</u>:
1.866.492.3176
<u>Web</u>:
ColoradoPAR.com

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)
- The ColoradoPAR Program will process PARs submitted by phone for:
  - emergent out-of-state
  - out-of area inpatient stays
  - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

PAR Letters/Inquiries

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is only number accepted when submitting claims
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the ColoradoPAR Program
  - ensure you have the right PAR type
  - e.g. Medical PAR may have been requested but processed as a Supply PAR

PARs Reviewed by the Department

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is the ONLY number accepted when submitting claims
- Long Term Care Nursing Facility PARs only

Waiver PARs

Community Center Board Adult & Children DHS Waivers

- Supported Living Services (SLS)
- Developmentally Disabled (DD)
- Children's Extensive Support (CES)
- Day Habilitation Services and Support (DHSS)

Community Center Board Children DHS Waivers

- Children's Habilitation Residential Program (CHRP)

Waiver PARs

Case Management Agency
Adult & Children HCPF Waivers

Elderly Blind and Disabled (EBD)	Children's Home Community Based Services (CHCBS)
Community Mental Health Services (CMHS)	Children With Autism (CWA)
Brain Injury (BI)	Children with Life Limiting Illness (CLLI)
Spinal Cord Injury (SCI)	

Transaction Control Number

Receipt Method

0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

Batch Number

Document Number

0 14 129 00 150 0 00037

Year of Receipt

Julian Date of Receipt

Adjustment Indicator

1 = Recovery
2 = Repayment

Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

Timely Filing

From "through" DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From DOS

- FQHC Separately Billed and additional Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date

Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CMS 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in Field 19 (Additional Claim Information)

Timely Filing – Medicare/Medicaid Enrollees

Medicare **pays** claim

- **120 days from Medicare payment date**

Medicare **denies** claim

- **60 days from Medicare denial date**

Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

Extensions – **Commercial Insurance**

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available

Extensions – **Delayed Notification**

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member

Extensions – **Backdated Eligibility**

- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
  - County technician
  - Member name
  - Delayed or backdated
  - Date eligibility was updated

CMS 1500

Who completes the CMS 1500?

- HCBS/Waiver providers
- Vision providers
- Physicians
- Supply providers
- Surgeons
- Transportation providers

CMS 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. 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 Fam. 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. Rsvd for NUCC Use

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.

CARRIER

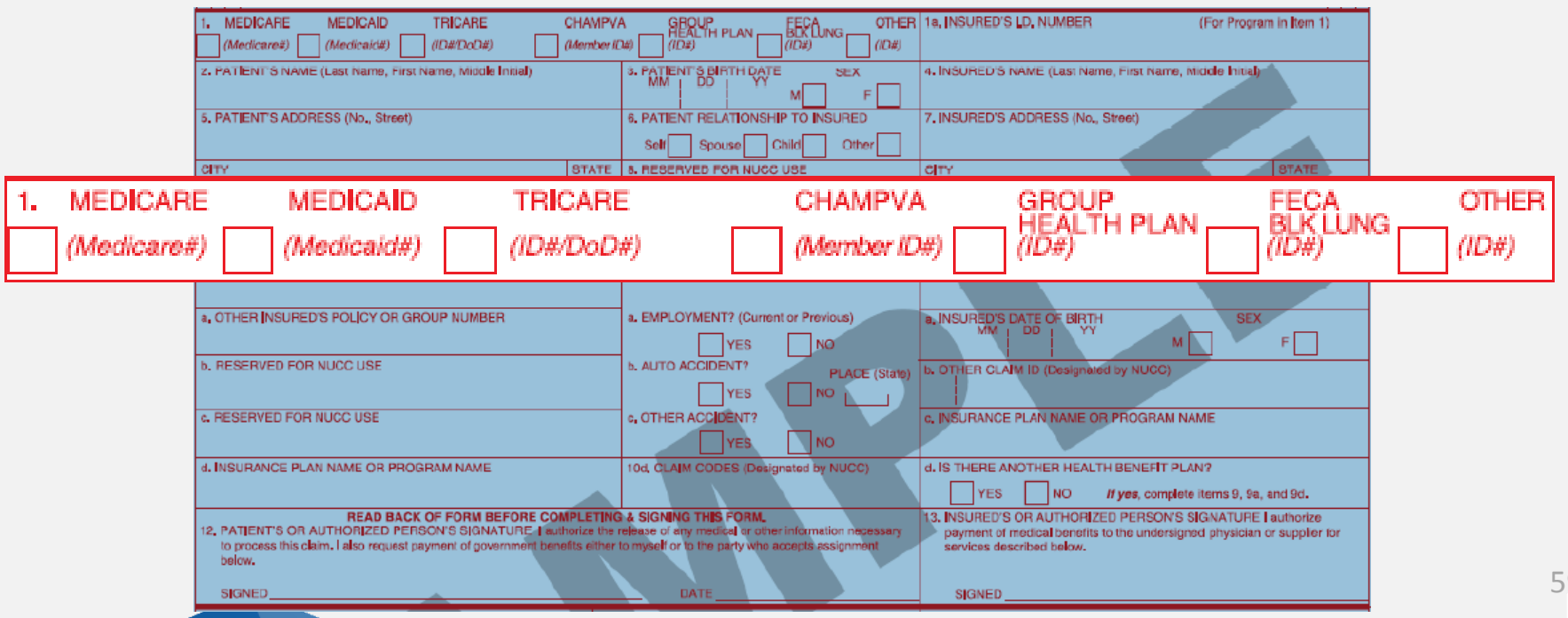
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

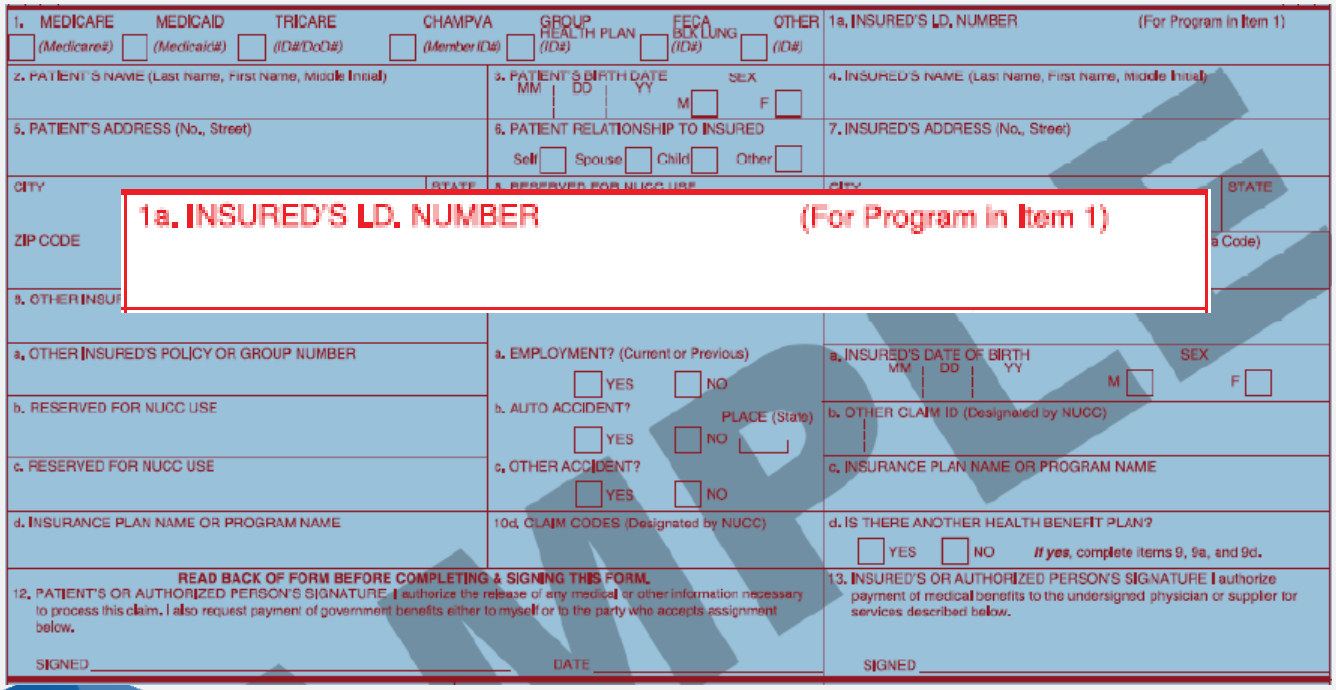
SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

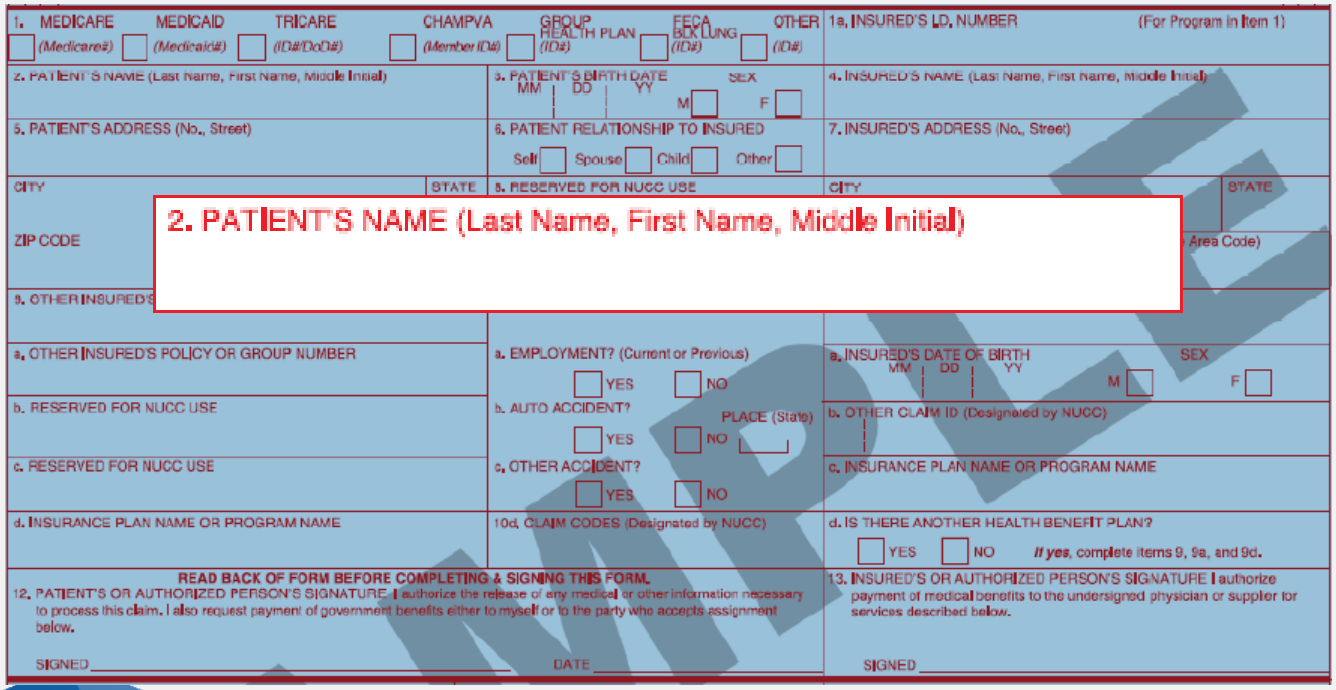
CMS 1500 Field Number	1
Field Title	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other
Requirement	Required
Instructions	Indicate the type of health insurance coverage applicable to this claim by placing an "X" in the appropriate box. Only one box can be marked.



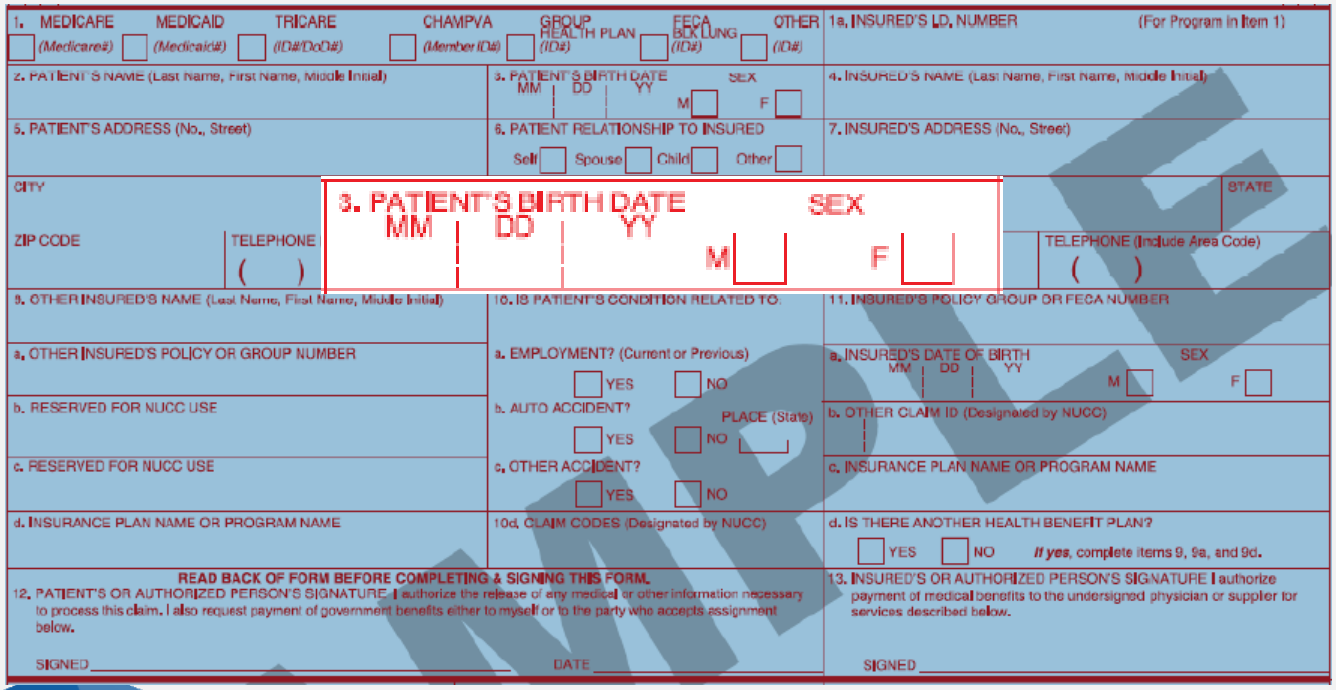
CMS 1500 Field Number	1a
Field Title	Insured's ID Number
Requirement	Required
Instructions	Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted.



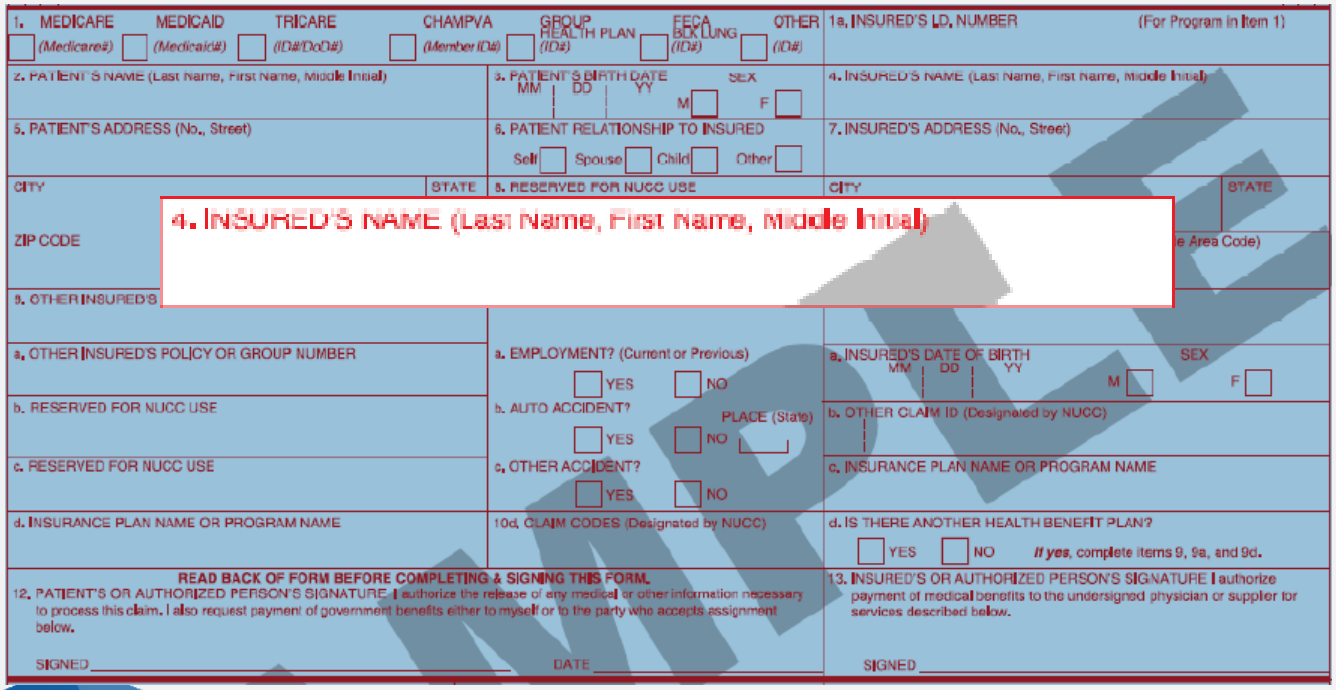
CMS 1500 Field Number	2
Field Title	Patient's Name
Requirement	Required
Instructions	Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.



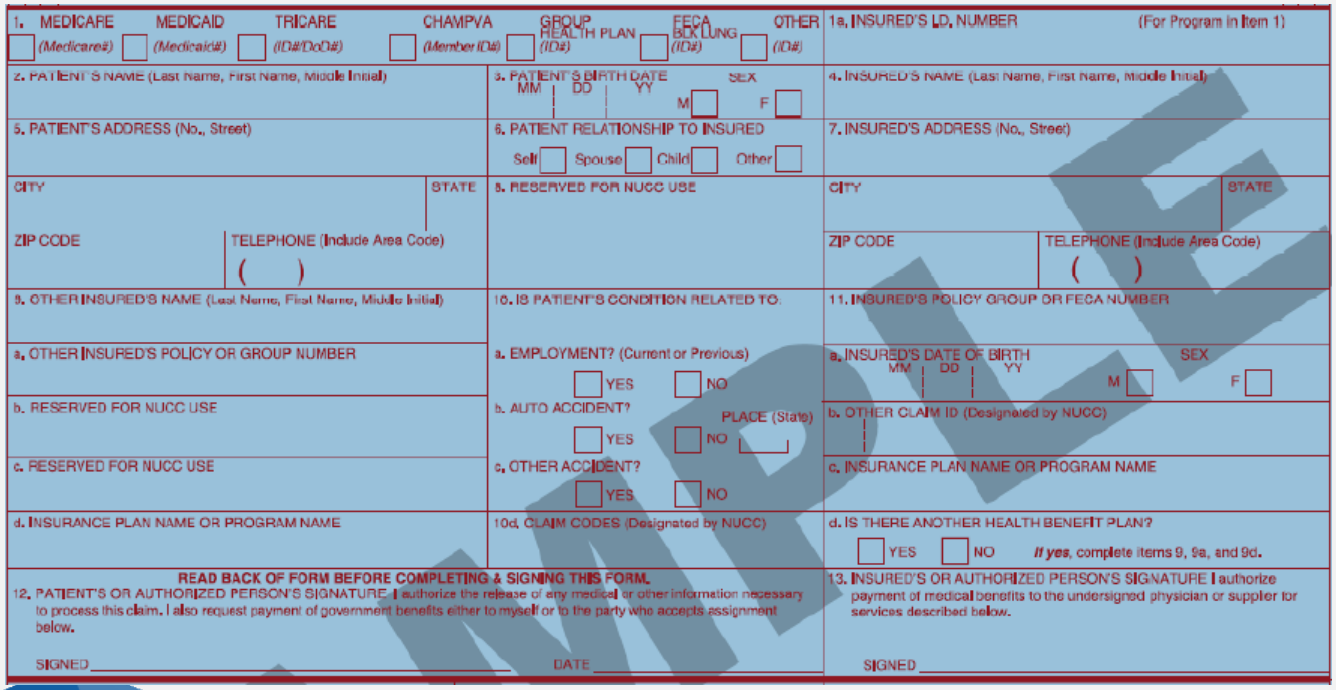
CMS 1500 Field Number	3
Field Title	Patient's Birth Date, Sex
Requirement	Required
Instructions	Enter the patient's eight-digit birth date MM/DD/YY). Place an "X" in the correct box to indicate the sex (gender) of the patient.



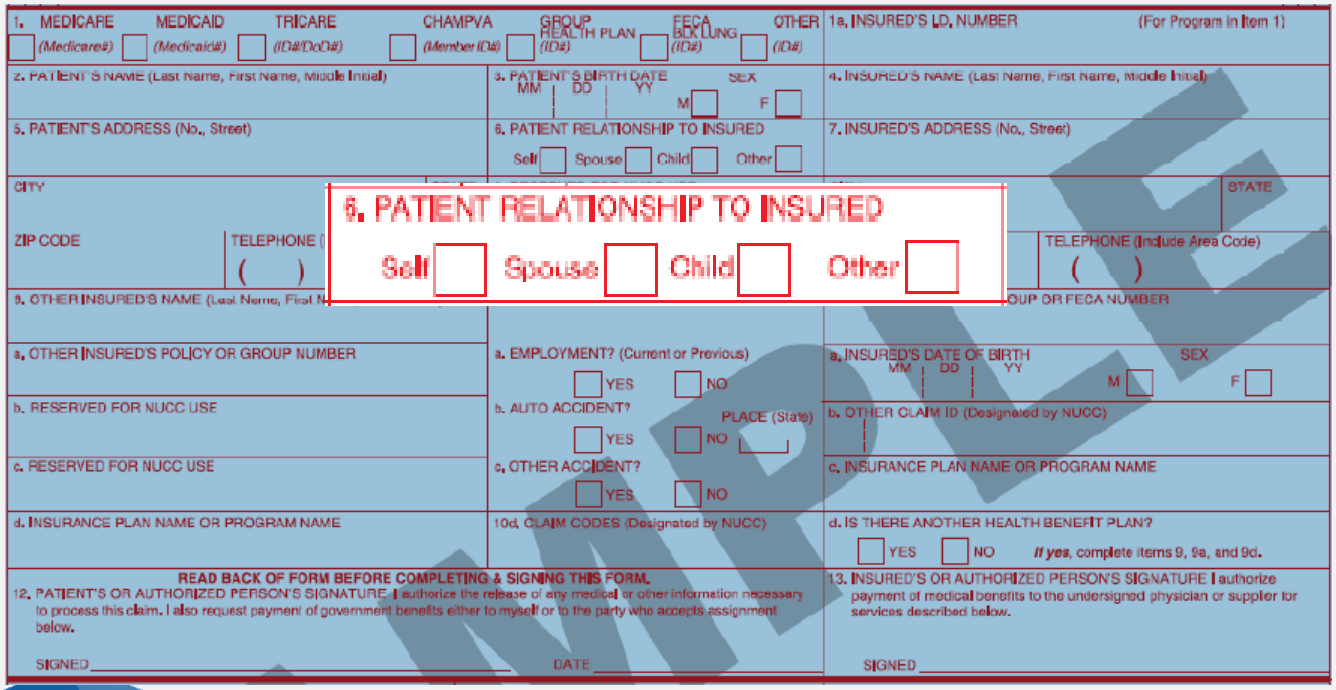
CMS 1500 Field Number	4
Field Title	Insured's Name
Requirement	Conditional
Instructions	Complete if the member is covered by a Medicare health insurance policy.



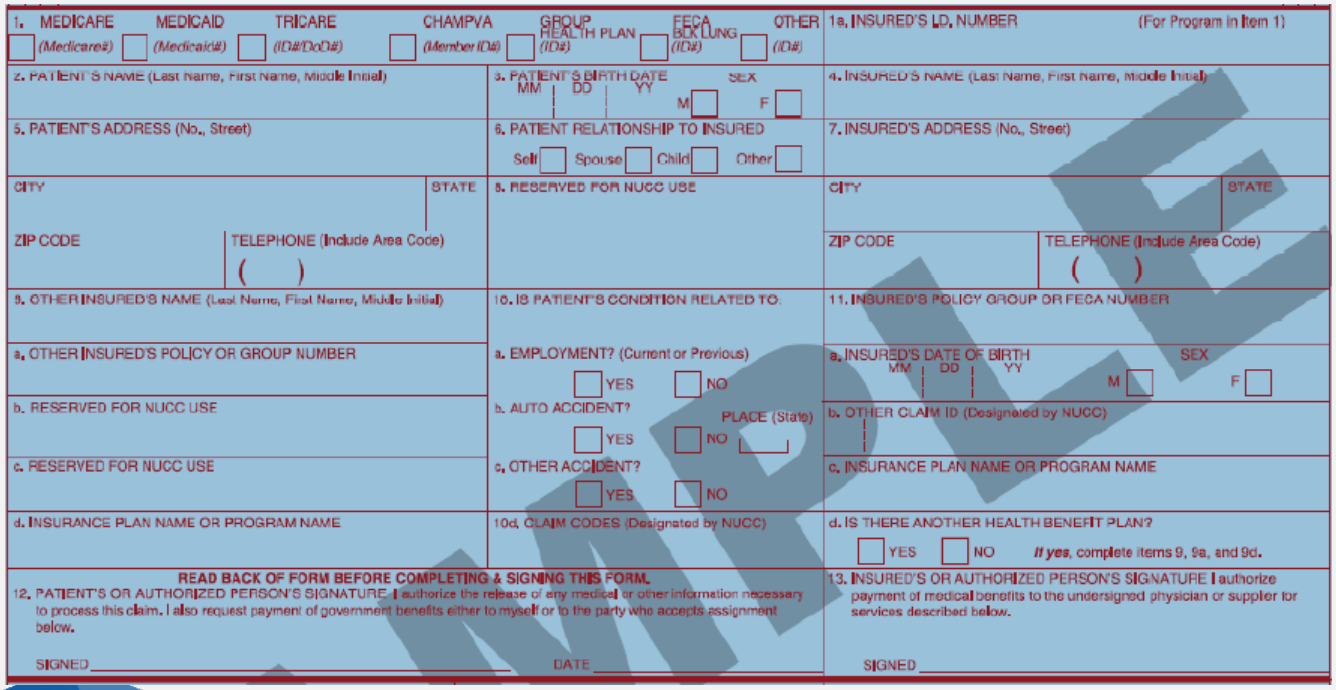
CMS 1500 Field Number	5
Field Title	Patient's Address
Requirement	Not Required
Instructions	


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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
ZIP CODE TELEPHONE (Include Area Code) ( )
8. RESERVED FOR NUCC USE
CITY STATE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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
SAMPLE

CMS 1500 Field Number	6
Field Title	Patient's Relationship to Insured
Requirement	Conditional
Instructions	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.

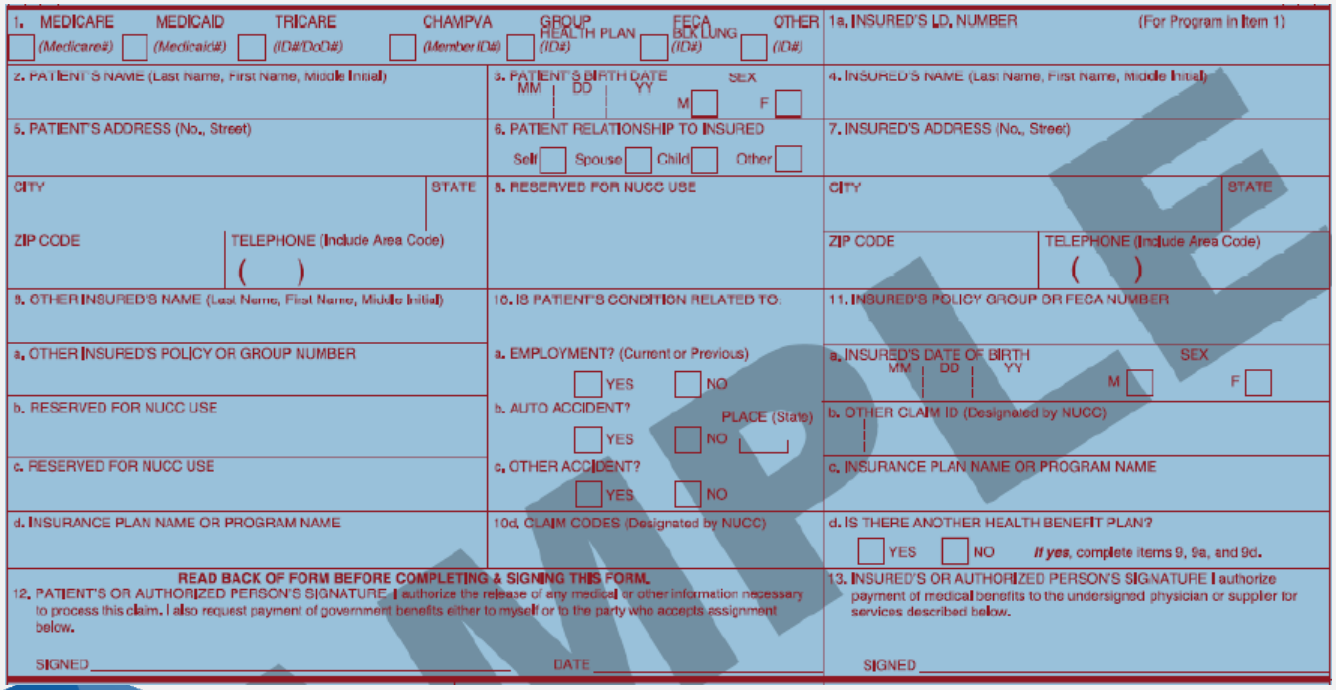


CMS 1500 Field Number	7
Field Title	Insured's Address
Requirement	Not Required
Instructions	


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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
ZIP CODE TELEPHONE (Include Area Code) ( )
8. RESERVED FOR NUCC USE
CITY STATE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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

SAMPLE

CMS 1500 Field Number	8
Field Title	Reserved for NUCC Use
Requirement	
Instructions	



1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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

ZIP CODE TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

CITY STATE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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.

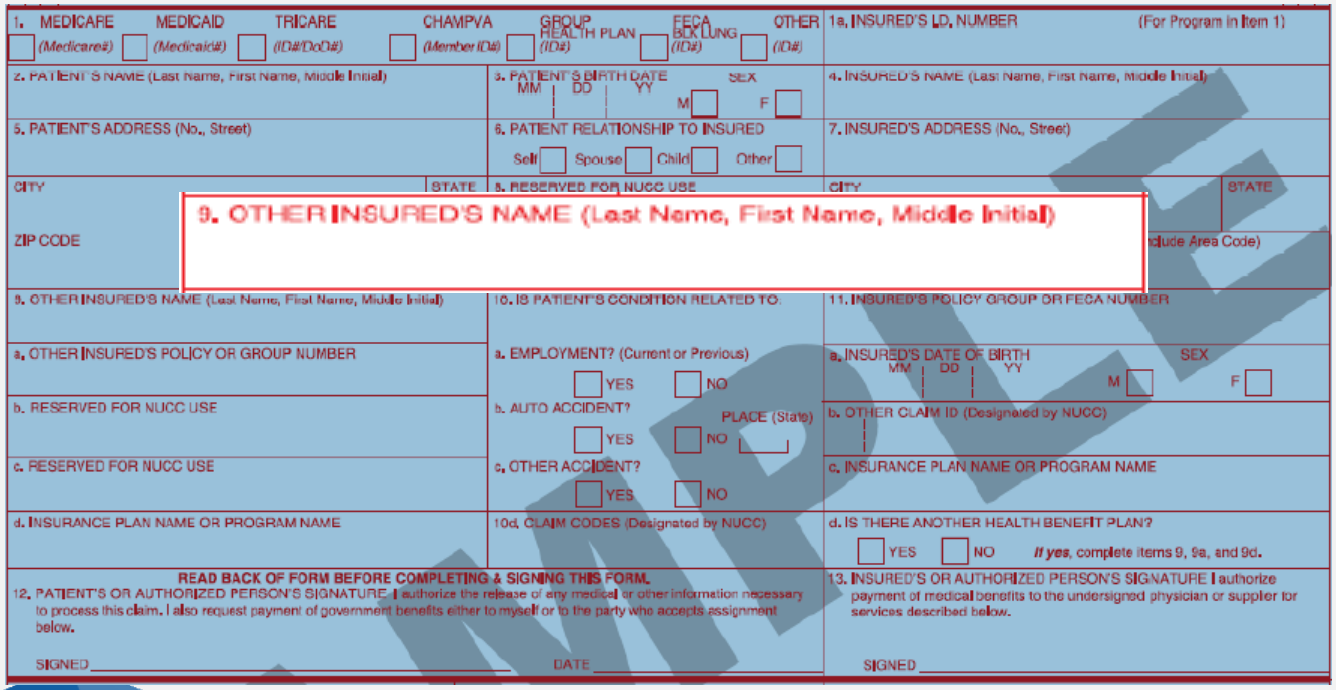
SIGNED DATE

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

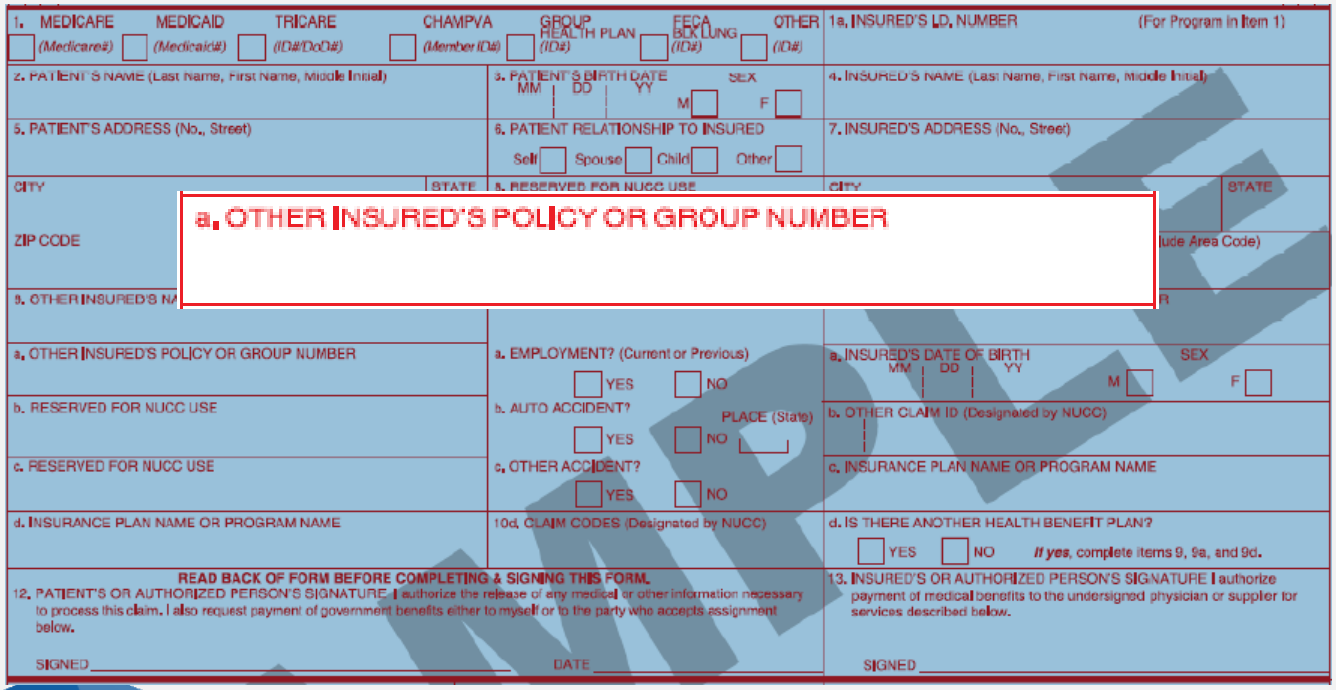
SIGNED

SAMPLE

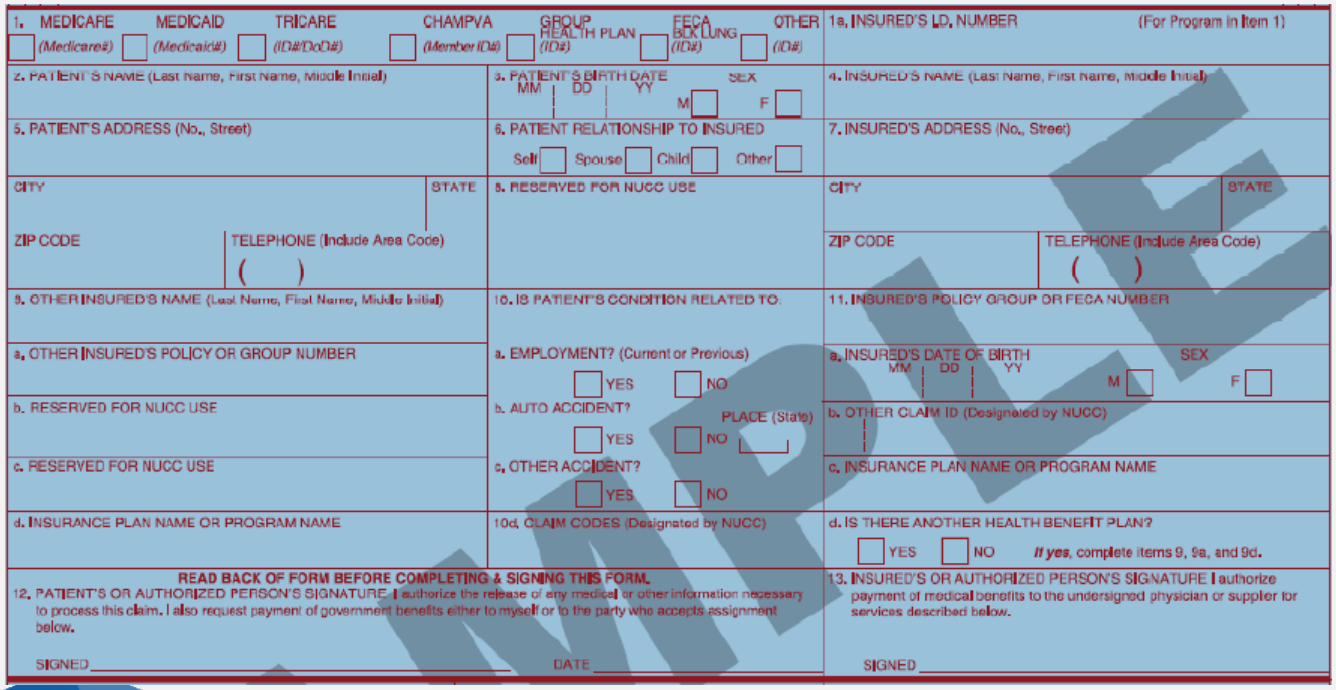
CMS 1500 Field Number	9
Field Title	Other Insured's Name
Requirement	Conditional
Instructions	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.



CMS 1500 Field Number	9a
Field Title	Other Insured's Policy or Group Number
Requirement	Conditional
Instructions	If field 11d is marked "yes", enter the policy or group number.

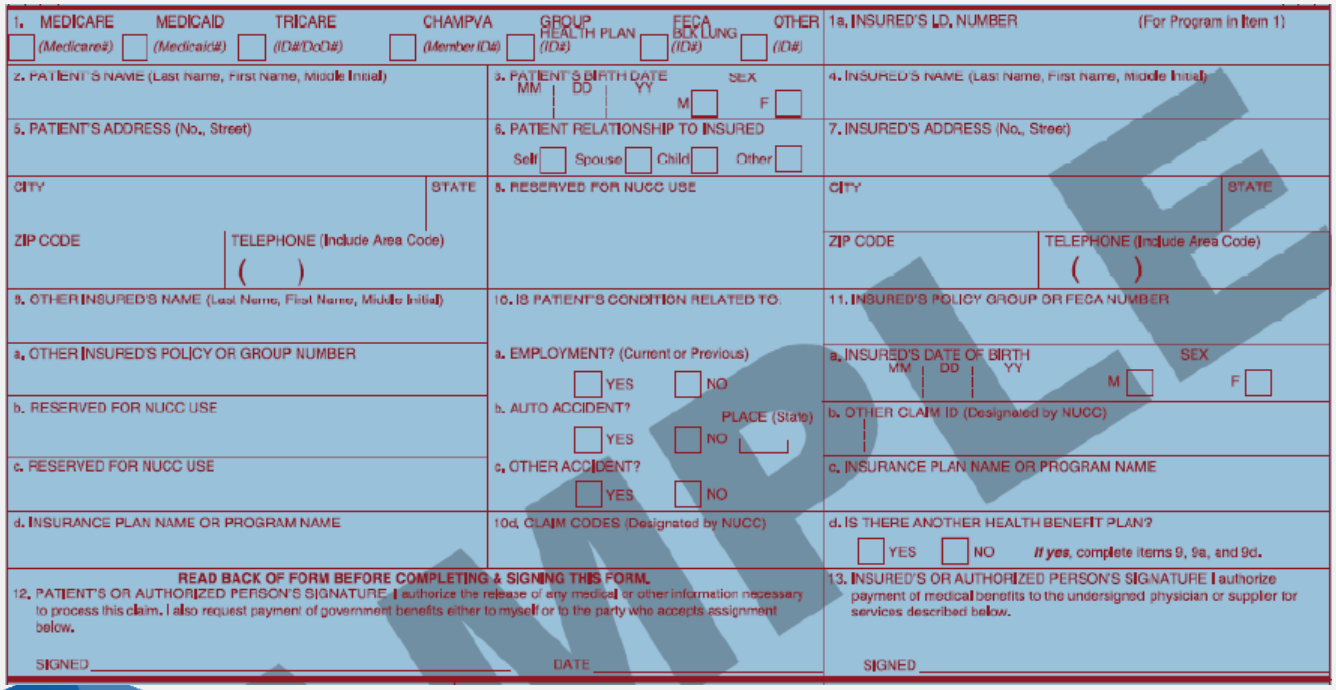


CMS 1500 Field Number	9b
Field Title	Reserved for NUCC Use
Requirement	Not Required
Instructions	


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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
ZIP CODE TELEPHONE (Include Area Code) ( )
8. RESERVED FOR NUCC USE
CITY STATE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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

SAMPLE

CMS 1500 Field Number	9c
Field Title	Reserved for NUCC Use
Requirement	Not Required
Instructions	


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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
ZIP CODE TELEPHONE (Include Area Code) ( )
8. RESERVED FOR NUCC USE
CITY STATE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
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SIGNED DATE
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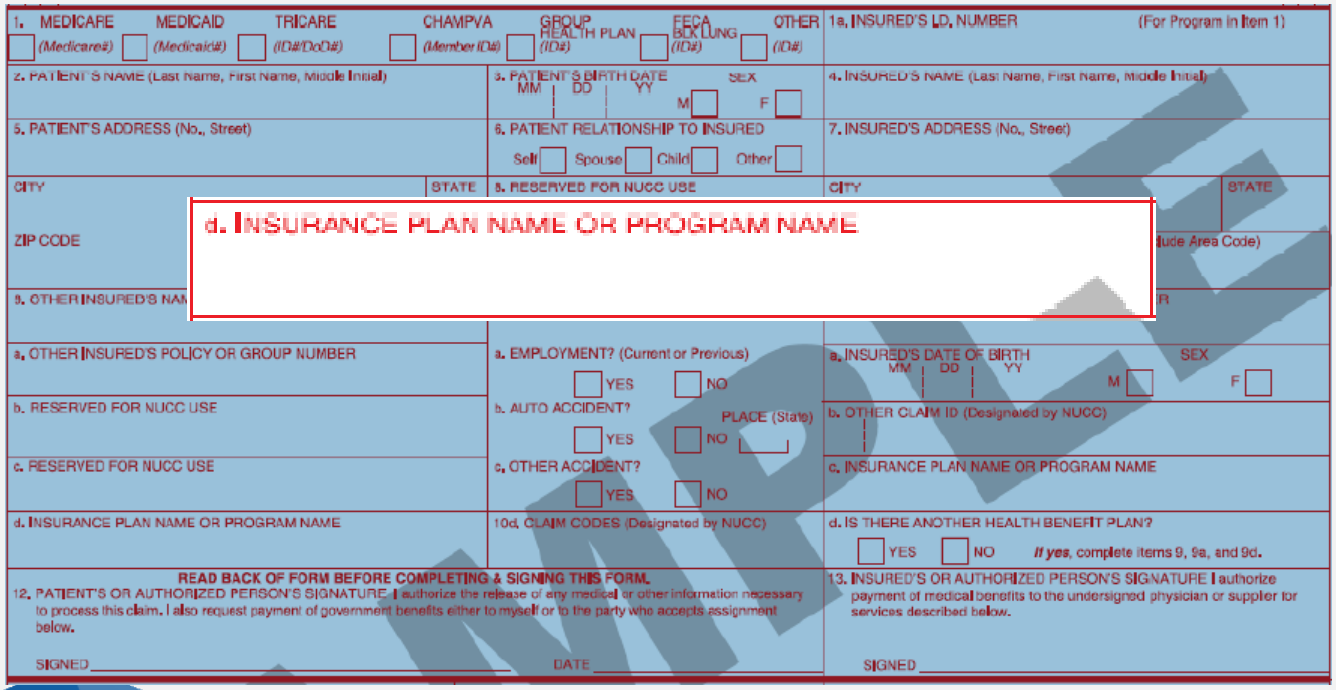
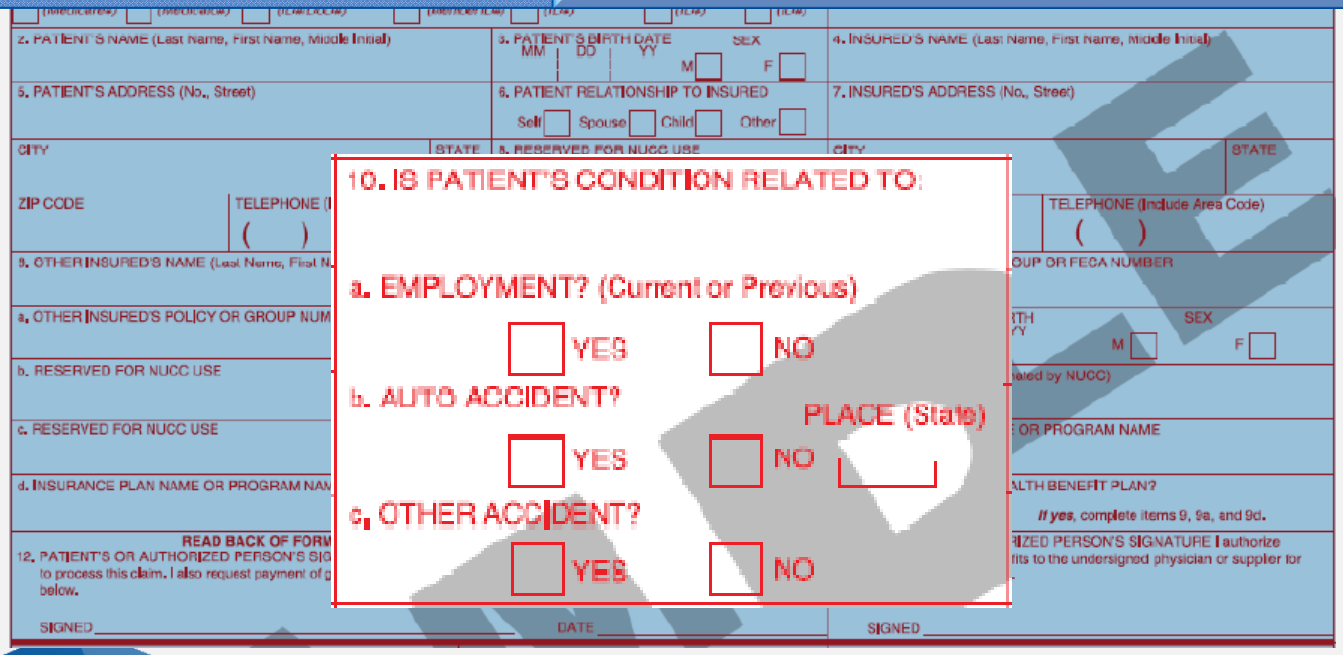
SIGNED

SAMPLE

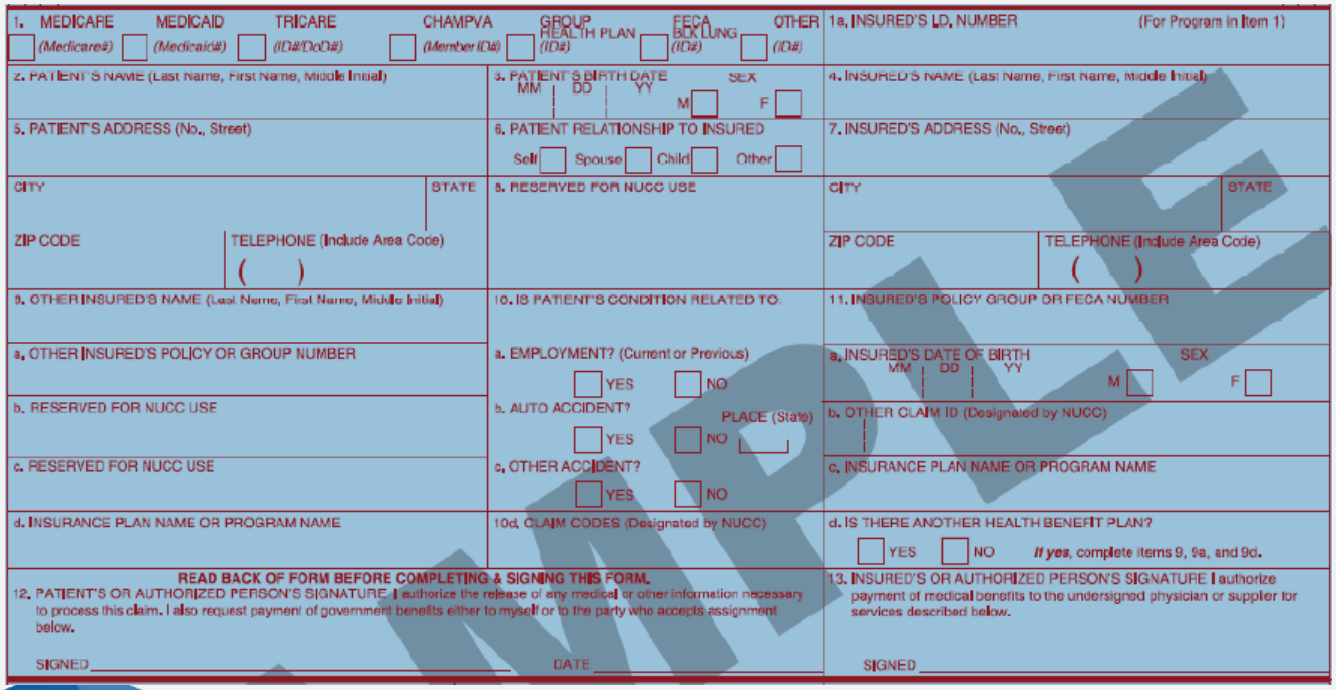
CMS 1500 Field Number	9d
Field Title	Insurance Plan Name or Program Name
Requirement	Conditional
Instructions	If field 11d is marked “yes” enter the insurance plan or program name.



CMS 1500 Field Number	10a-c
Field Title	Is Patient's Condition Related To:
Requirement	Conditional
Instructions	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.



CMS 1500 Field Number	10d
Field Title	Reserved for Local Use
Requirement	Not Required
Instructions	


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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
ZIP CODE TELEPHONE (Include Area Code) ( )
8. RESERVED FOR NUCC USE
CITY STATE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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
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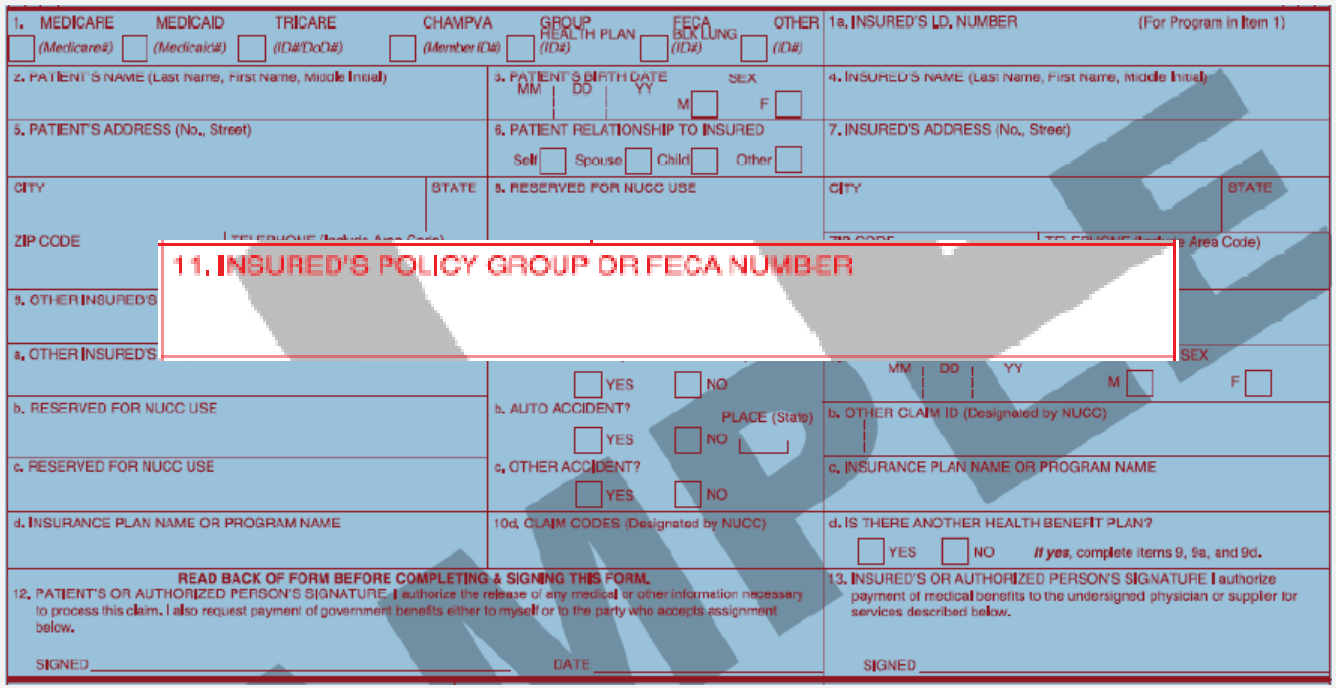
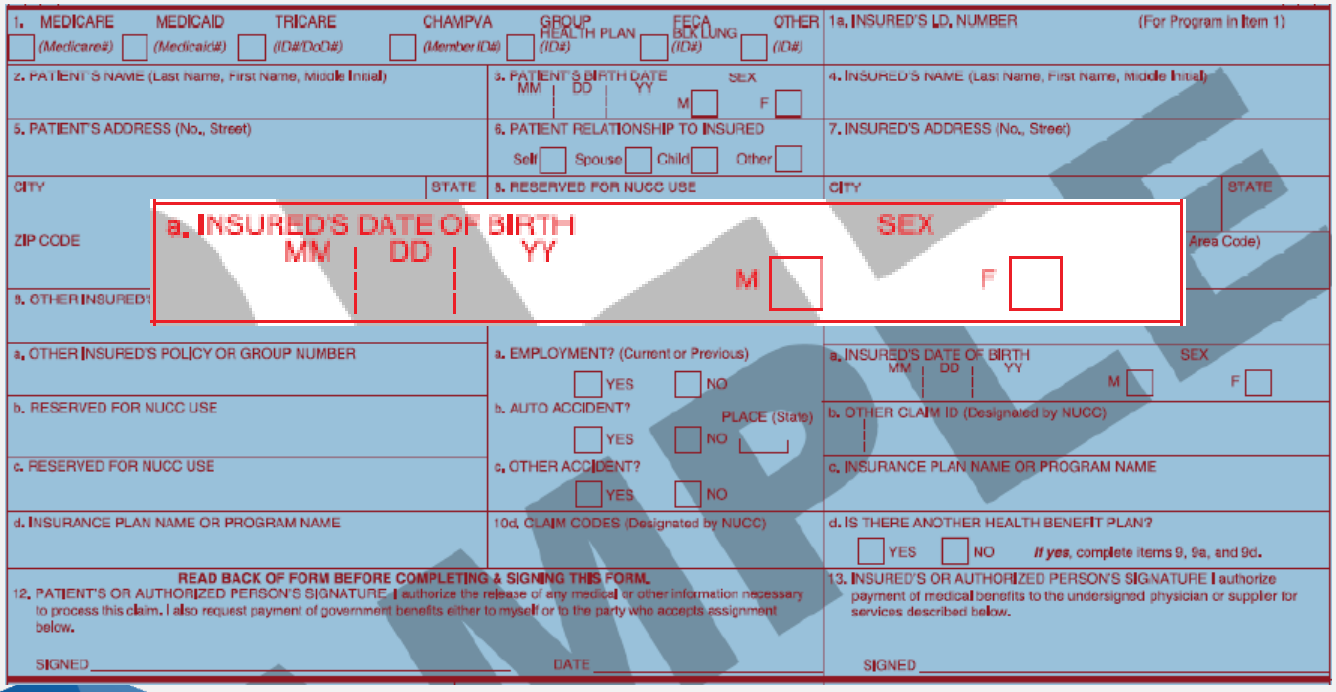
SIGNED

SAMPLE

CMS 1500 Field Number	11
Field Title	Insured's Policy, Group, or FECA Number
Requirement	Conditional
Instructions	Complete if the member is covered by a Medicare health insurance policy.



CMS 1500 Field Number	11a
Field Title	Insured's Date of Birth, Sex
Requirement	Conditional
Instructions	Complete if the member is covered by a Medicare health insurance policy. Place an "X" in the appropriate box to indicate the sex of the insured.


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE
Area Code)
9. OTHER INSURED'
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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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
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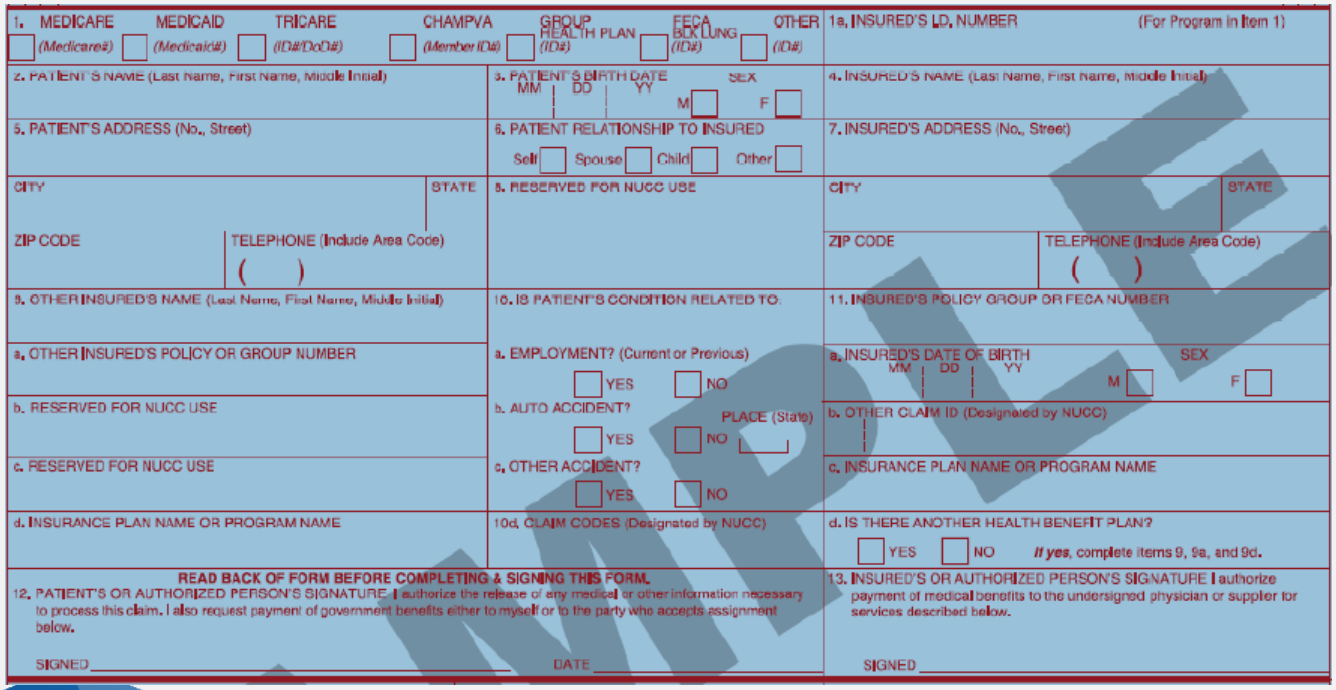
SIGNED

CMS 1500 Field Number	11b
Field Title	Other Claim ID
Requirement	Not Required
Instructions	


1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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
ZIP CODE TELEPHONE (Include Area Code) ( )
8. RESERVED FOR NUCC USE
CITY STATE
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. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State) YES NO
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
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
SAMPLE

CMS 1500 Field Number	11c
Field Title	Insurance Plan Name or Program Name
Requirement	Not Required
Instructions	

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) 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

ZIP CODE TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

CITY STATE

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. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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 _____

SAMPLE

S 1500 Field Number	11d
d Title	Is there another Health Benefit Plan?
uirement	Conditional
ructions	When appropriate, place an “X” in the correct box. If marked YES, complete 9, 9a and 9d.

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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

ZIP CODE

Area Code)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES NO *If yes*, complete items 9, 9a, and 9d.

9. OTHER INSURED'S

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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

SAMPLE

S 1500 Field Number	12
d Title	Patient’s or Authorized Person’s Signature
uirement	Required
ructions	Enter “Signature on File”, “SOF”, or legal signature. If there is no signature on file, leave blank or enter “No Signature on File”. Enter the date the claim form was signed.

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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

ZIP CODE Code)

9. OTHER INSU

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

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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

SAMPLE

S 1500 Field Number	13
d Title	Insured’s or Authorized Person’s Signature
uirement	Not Required
uctions	

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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.

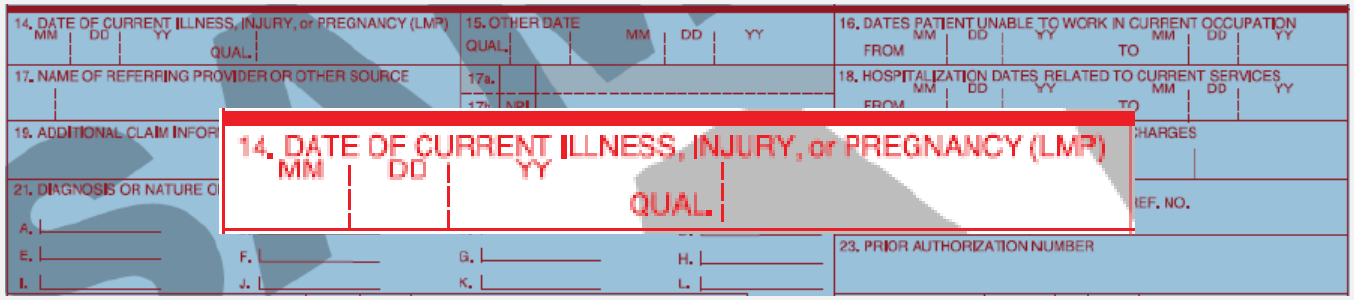
SIGNED DATE

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

MPLE

S 1500 Field Number	14
d Title	Date of Current Illness, Injury, or Pregnancy
uirement	Conditional
ructions	Complete if information is known. Enter the date of illness, injury or pregnancy.



S 1500 Field Number	15
d Title	Other Date
uirement	Not Required
ructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

SAMPLE

S 1500 Field Number	16
d Title	Dates Patient Unable to Work in Current Occupation
uirement	Not Required
ructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

SAMPLE

S 1500 Field Number	17
d Title	Name of referring Provider or Other Source
uirement	Not Required
ructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

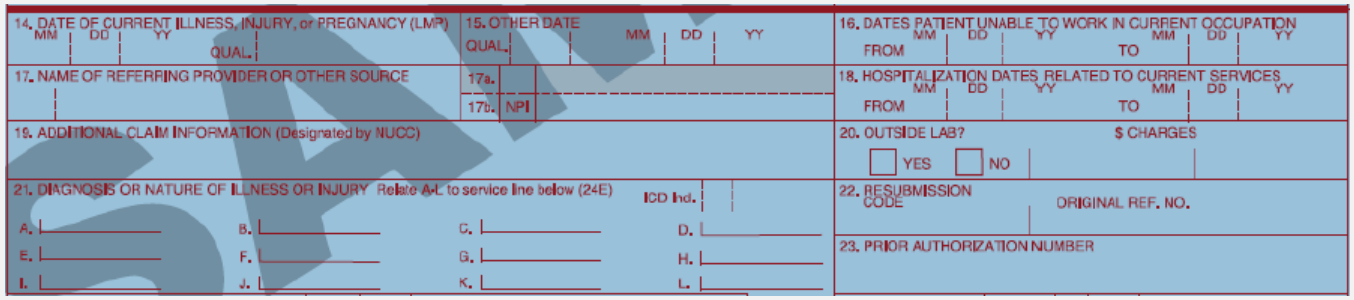
SAMPLE

S 1500 Field Number	17a
d Title	Other ID#
uirement	Not Required
ructions	

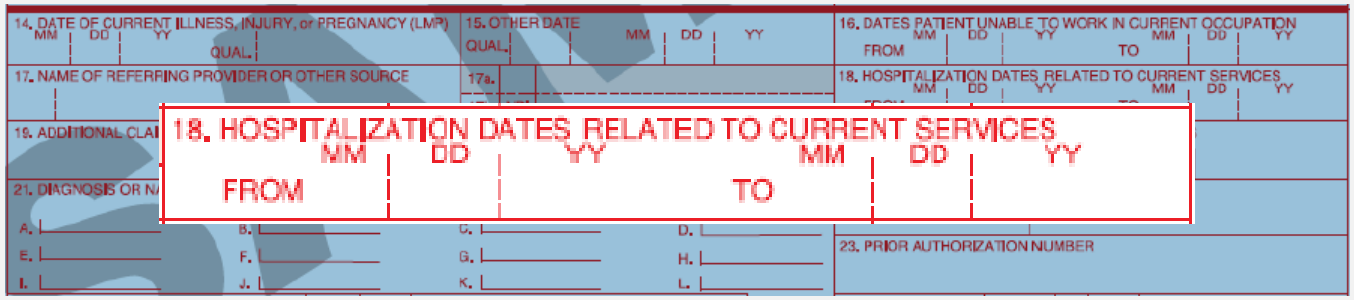
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

SAMPLE

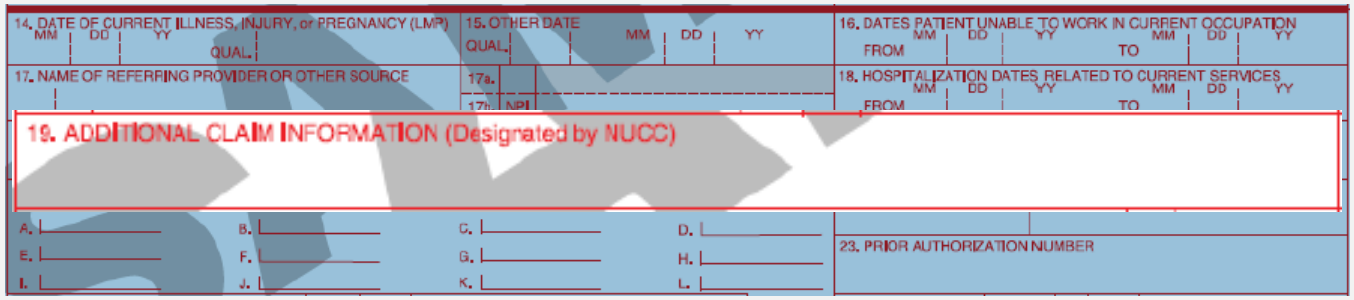
S 1500 Field Number	17b
d Title	NPI #
uirement	Not Required
ructions	



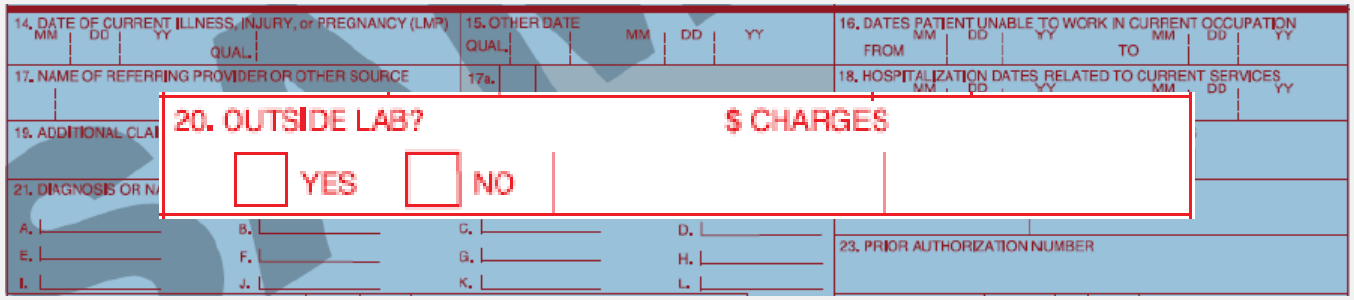
S 1500 Field Number	18
d Title	Hospitalization Dates Related to Current Services
uirement	Conditional
ructions	Complete for services provided in an inpatient hospital setting. If the member is still hospitalized, the discharge date may be omitted.



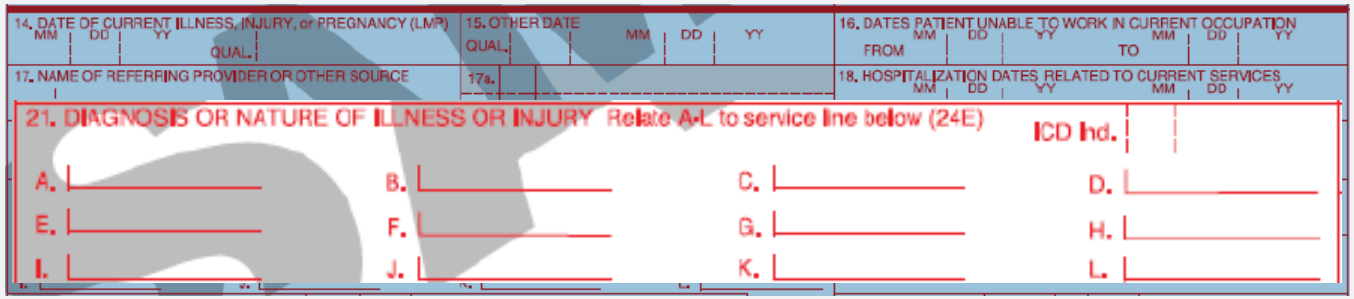
S 1500 Field Number	19
d Title	Additional Claim Information
uirement	Conditional
uctions	Use to document the Late Bill Override Date for timely filing. When applicable, enter the word “TRANSPORT CERT” to certify that you have a transportation certificate on file for this service.



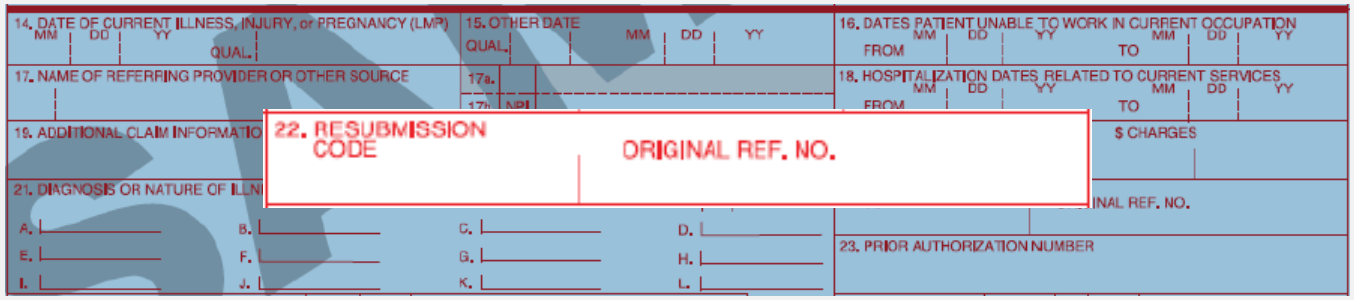
S 1500 Field Number	20
d Title	Outside Lab? $ Charges
uirement	Conditional
ructions	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Enter the charge amount for this service.



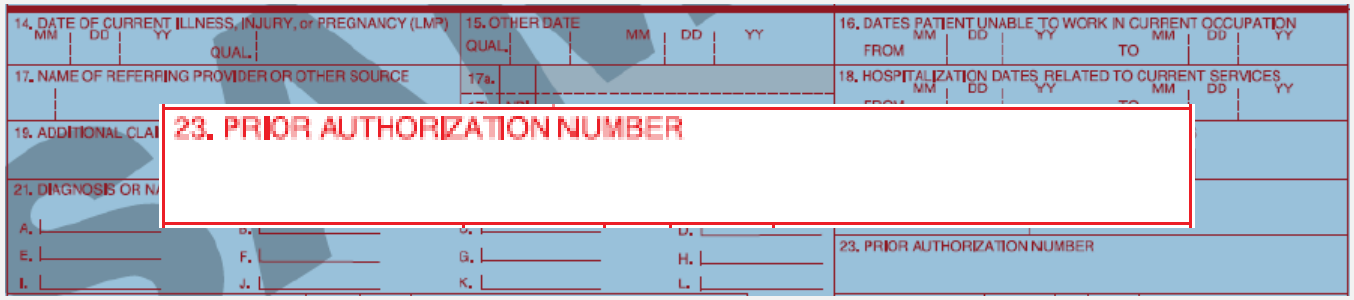
S 1500 Field Number	21
d Title	Diagnosis or Nature of Illness or Injury
uirement	Required
ructions	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter the applicable ICD indicator to identify which version of ICD codes is being reported.



S 1500 Field Number	22
d Title	Resubmission and/or Original Reference Number
uirement	Conditional
ructions	List the Original reference number for the resubmitted claim. This field is not intended for use for original claim submissions.



S 1500 Field Number	23
d Title	Prior Authorization Number
uirement	Conditional
ructions	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.



S 1500 Field Number	24A
d Title	Date(s) of Service
uirement	Required
ructions	Enter date(s) of service, both the “From” and “To” dates. If there is only one date of service, enter the date under “From”. Leave “To” blank or re-enter “From” date. This field allows for data to be entered in the MM/DD/YY format.

ATE(S) OF SERVICE				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. #
YY	MM To DD	YY											
												NPI	
												NPI	
												NPI	

S 1500 Field Number	24B
d Title	Place of Service
uirement	Required
ructions	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.

ATE(S) OF SERVICE				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. #
YY	MM	To DD	YY									NPI	
												NPI	
												NPI	

CMS 1500 Field Number	24C
Field Title	EMG
Requirement	Conditional
Instructions	If the service is an emergency, place an “Y” for YES in the bottom, unshaded area of the field.

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. #
										NPI	
										NPI	
										NPI	

CMS 1500 Field Number	24D
Field Title	Procedures, Services, or Supplies
Requirement	Required
Instructions	Inter the CPT or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers.

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. #
										NPI	
										NPI	
										NPI	

CMS 1500 Field Number	24E
Field Title	Diagnosis Pointer
Requirement	Required
Instructions	Enter the diagnosis code reference letter as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first.

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. #
														NPI	
														NPI	
														NPI	

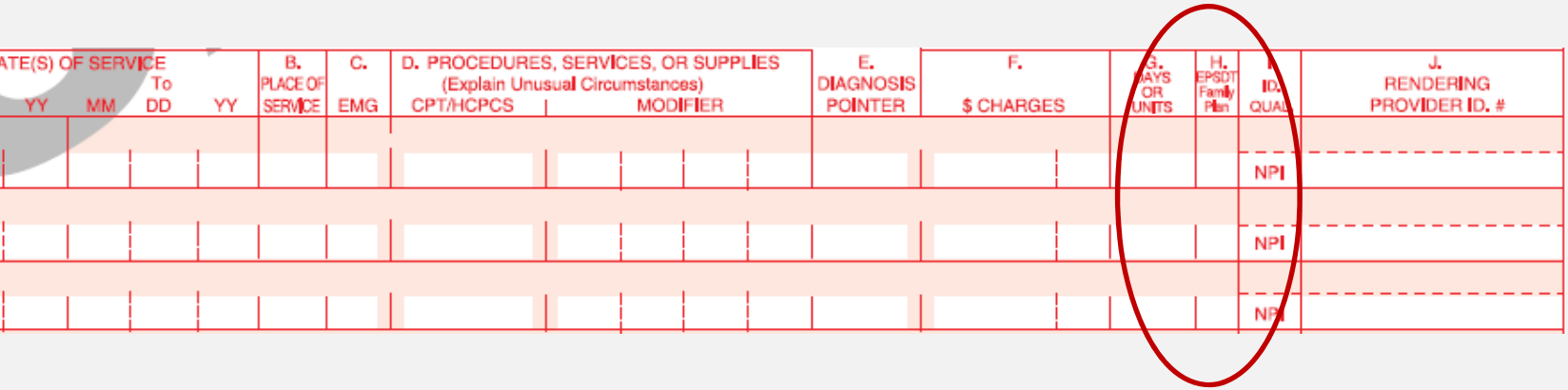
CMS 1500 Field Number	24F
Field Title	$ Charges
Requirement	Required
Instructions	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

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. #
										NPI	
										NPI	
										NPI	

CMS 1500 Field Number	24G
Field Title	Days or Units
Requirement	Required
Instructions	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.

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. #
														NPI	
														NPI	
														NPI	

S 1500 Field Number	24H
d Title	EPSDT/Family Plan
uirement	Conditional
ructions	EPSDT- enter the qualifier response in the shaded portion of the field. Family Planning- if the service if for Family Planning, enter “Y” for YES or “N” for NO in the bottom, unshaded portion of the field.



S 1500 Field Number	24I
d Title	ID Qualifier
uirement	Not Required
uctions	

ATE(S) OF SERVICE				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. #
YY	MM	To DD	YY									NPI	
												NPI	
												NPI	

S 1500 Field Number	24J
d Title	Rendering Provider ID #
uirement	Required
ructions	In the unshaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or rendered the billed service.

ATE(S) OF SERVICE		To		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. #
YY	MM	DD	YY										
												NPI	
												NPI	
												NPI	

S 1500 Field Number	25
d Title	Federal Tax ID Number
uirement	Not Required
ructions	

. 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. Rsvd for NUCC Use
RE OF PHYSICIAN OR SUPPLIER NG DEGREES OR CREDENTIALS at the statements on the reverse is bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
DATE	a. NPI	b.	a. NPI	b.	

CMS 1500 Field Number	26
Field Title	Patient's Account Number
Requirement	Optional
Instructions	Enter the information that identifies the patient or claim in the provider's billing system.

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. Rsvd for NUCC Use
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.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

26. PATIENT'S ACCOUNT NO.

CMS 1500 Field Number	27
Field Title	Accept Assignment?
Requirement	Required
Instructions	The accept assignment indicates that the provider agrees accept assignment under the terms of the payer's program.

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. Rsvd for NUCC Use
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.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

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

CMS 1500 Field Number	28
Field Title	Total Charge
Requirement	Required
Instructions	Enter the sum of all charges listed in field 24F.

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. Rsvd for NUCC Use
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.)	32. SERVICE FACILITY LOCATION INFORMATION	28. TOTAL CHARGE $	33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

CMS 1500 Field Number	29
Field Title	Amount Paid
Requirement	Conditional
Instructions	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services.

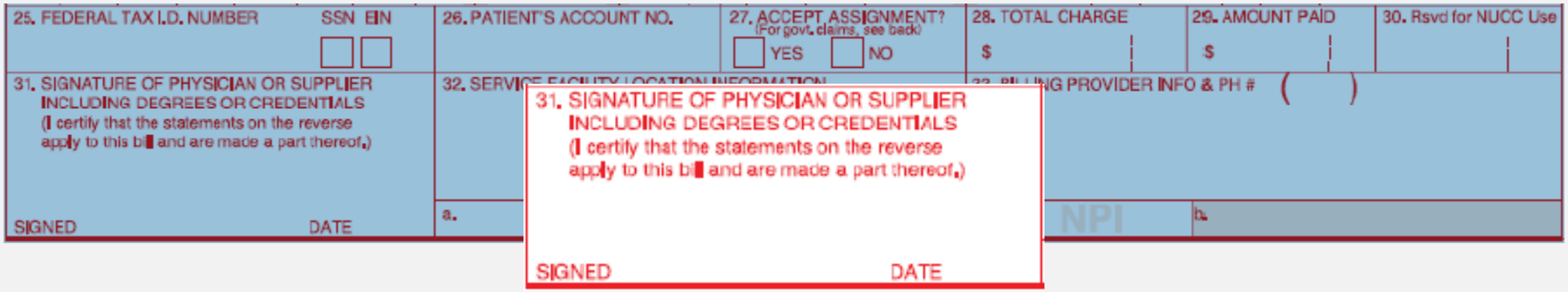
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

29. AMOUNT PAID
$

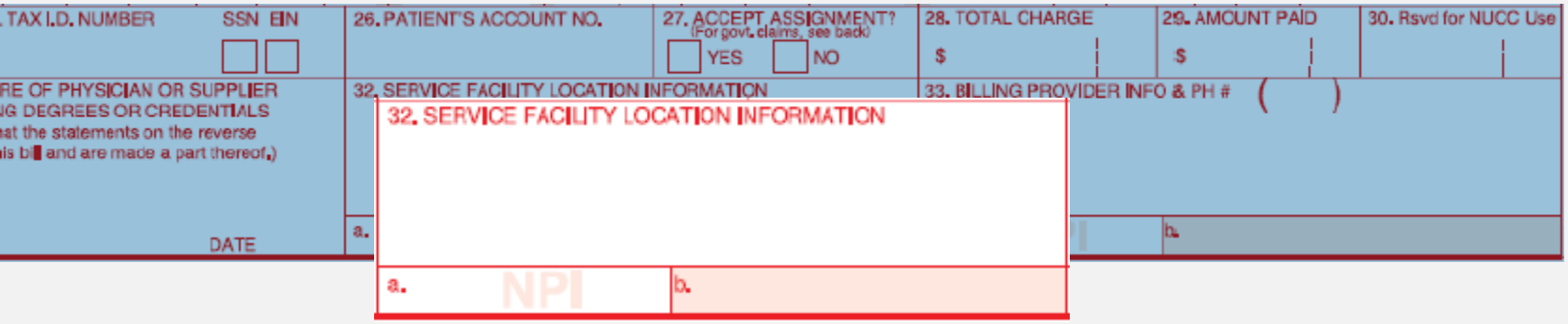
CMS 1500 Field Number	30
Field Title	Rsvd for NUCC Use
Requirement	Not Required
Instructions	

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. Rsvd for NUCC Use
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.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

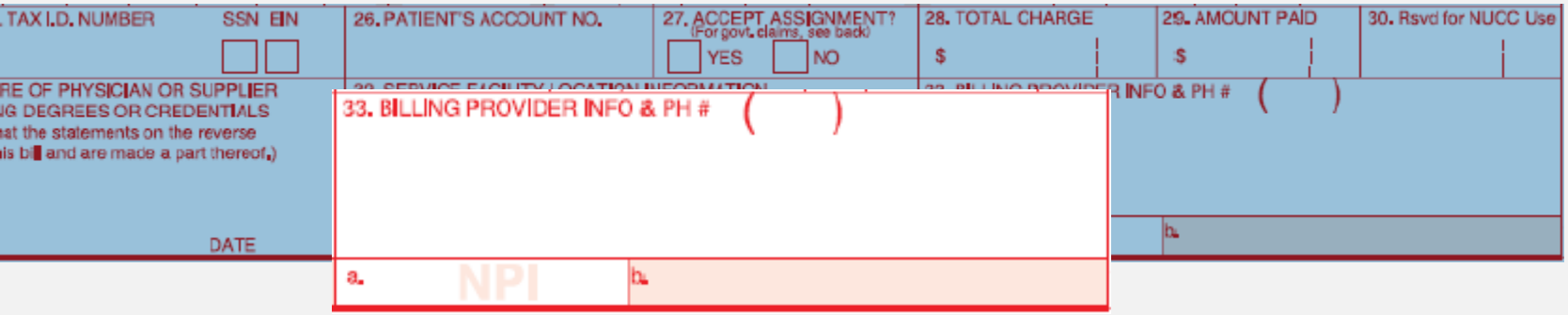
CMS 1500 Field Number	31
Field Title	Signature of Physician or Supplier Including Degrees or Credentials
Requirement	Required
Instructions	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. Enter the date the claim form was signed.



S 1500 Field Number	32
d Title	Service Facility Location Information
uirement	Conditional
ructions	Complete for services provided in a hospital or nursing facility. 32a- enter the NPI of the billing provider 32b- enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



S 1500 Field Number	33
d Title	Billing Provider Info & Ph #
uirement	Required
ructions	Enter the name of the individual or organization that will receive payment for the billed services. 33a- enter the NPI of the billing provider 33b- enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



Common Denial Reasons

mely Filing	Claim was submitted more than 120 days without a LBOD
uplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid.
l Medicare or her Insurance	Medicaid is always the “Payor of Last Resort”. Provider should bill all other appropriate carriers first
R not on file	No approved authorization on file for services that are being submitted
tal Charges valid	Line item charges do not match the claim total

Claims Process - Common Terms

ject

Claim has primary data edits – **not** accepted by claims processing system

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

Claim processed & paid by claims processing system

Claims Process - Common Terms

Correcting under/overpayments, claims paid at zero & claims history info

justment

Re-bill previously denied claim

Rebill

Claim must be manually reviewed before adjudication

spend

"Cancelling" a "paid" claim (wait 48 hours to rebill)

Void

Adjusting Claims

hat is an adjustment?

- Adjustments create a replacement claim
- Two step process: Credit & Repayment

Adjust a claim when:

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when:

- Claim was denied
- Claim is in process
- Claim is suspended

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track

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

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

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Paper

- Use Medicaid Resubmission **Reason Code 7** to **replace** a prior claim or **Reason Code 8** to **void/cancel** a claim. The TCN that needs to be **replaced or voided** is the original reference number. Providers will continue to see Reason Code 406 for replacement claims and Reason Code 412 for voided claims on the Provider Claim Reports.

Provider Claim Reports (PCRs)

ontains the following claims information:

- Paid
- Denied
- Adjusted
- Voided
- In process

oviders required to retrieve PCR through File & Report rvice (FRS)

- Via Web Portal

Provider Claim Reports (PCRs)

ailable through FRS for 60 days

vo options to obtain duplicate PCRs:

- Fiscal agent will send encrypted email with copy of PCR attached
  - $2.00/ page
- Fiscal agent will mail copy of PCR via FedEx
  - Flat rate- $2.61/ page for business address
  - $2.86/ page for residential address

arge is assessed regardless of whether request made thin 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

****

* CLAIMS PAID *

****

ICE	---------- CLIENT ----------		TRANSACTION	DATES OF SVC		TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT
JM	-------- NAME --------	STATE ID	CONTROL NUMBER	FROM	TO	CHARGES	CHARGES	PAID	SOURCES	AMOUNT
15	CLIENT, IMA	Z000000	04080000000000001	040508	040508	132.00	69.46	2.00	0.00	69.46
C CODE - MODIFIER 99214 -				040508	040508	132.00	69.46	2.00		

TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46

Denied

* CLAIMS DENIED *

****

	---------- CLIENT	----------	TRANSACTION	DATES OF SERVICE		TOTAL	----- DENIAL REASONS ----
	---------- NAME	---------- STATE ID	CONTROL NUMBER	FROM	TO	DENIED	------ ERROR CODES -----
CCIOT	CLIENT, IMA	A000000	30800000000000003	03/05/08	03/06/08	245.04	1348

TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

OLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'. COUNT 0001

Provider Claim Reports (PCRs)

Adjustments

****
* ADJUSTMENTS PAID *
****

--- CLIENT ------ NAME -------	---------- STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00	92.82-
ODE - MOD T1019 - U1		041008	091808		92.82	92.82-				
CLIENT, IMA	A000000	40800000000200002	041008	041808	406	114.24	114.24	0.00	0.00	114.24
ODE - MOD T1019 - U1		041008	041808		114.24	114.24				
				NET IMPACT		21.42				

Recovery

Net Impact

Repayment

Voids

****
* ADJUSTMENTS PAID *
****

LIENT ------ NAME -------	---------- STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
IENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00	642.60-
E - MOD T1019 - U1		040608	042008			642.60-	642.60-			
				NET IMPACT		642.60-				

Provider Services

Xerox
1-800-237-0757

- Claims/Billing/ Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank You!