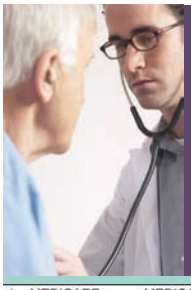
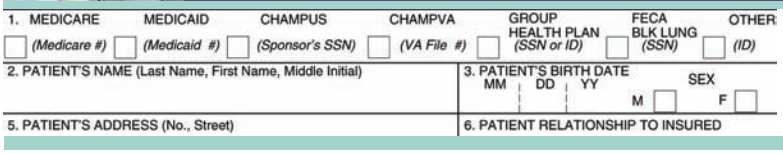


Form CMS-1500
At A Glance



What is the Form CMS-1500?

The Form CMS-1500 is the standard paper claim form used by health care professionals and suppliers to bill Medicare Carriers or Part A/B and Durable Medical Equipment Medicare Administrative Contractors (A/B MACs and DME MACs).

A claim is a request for payment of Medicare benefits for services furnished by a health care professional or supplier. Claims must be submitted within one year from the date of service and Medicare beneficiaries cannot be charged for completing or filing a claim. Offenders may be subject to penalty for violations.

Exceptions to Mandatory Electronic Claim Submission

The Administrative Simplification Compliance Act (ASCA) prohibits payment of services or supplies not submitted to Medicare electronically, with limited exceptions. Medicare will receive and process paper claims from health care professionals and suppliers who meet the exceptions to the requirements set forth in the ASCA.

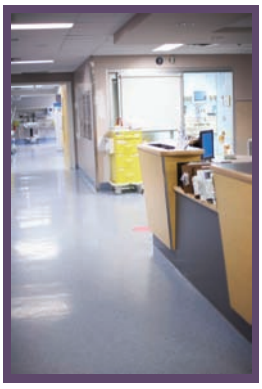
Some circumstances *always* meet the exception criteria

Health care professionals and suppliers that experience one of these unusual circumstances are automatically waived from the electronic claim submission requirement for either the indicated claim type or the period when the unusual circumstance exists.

A listing of these definitive exceptions and the latest information on CMS regulations regarding the limited acceptance of paper claims in lieu of electronic billing may be found at *http://www.cms.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp* on the CMS website. These circumstances include:

- A physician, practitioner, or supplier that bills a Medicare Carrier, A/B MAC, or DME MAC and has fewer than 10 Full-Time Equivalent (FTE) employees.
- A health care professional or supplier experiencing a disruption in electricity and communication connections that is beyond its control.

Health care professionals and suppliers are to self-assess to determine if they meet one or more of these situations and should not submit a waiver request to their contractor. If one of these circumstances applies, they may submit claims to Medicare on paper or via other non-electronic means.



Chapter 26 of the *Medicare Claims Processing Manual* (Pub. 100-04) provides detailed information on completing the Form CMS-1500.

This manual may be found at *http://www.cms.gov/manuals/downloads/clm104c26.pdf* on the CMS website.

Other waiver request circumstances may meet the exception criteria

Medicare pre-approval must be obtained to submit paper claims in the following situations:

- Any situation where a health care professional or supplier can demonstrate that the applicable adopted Health Insurance Portability and Accountability Act (HIPAA) claim standard does not permit submission of a particular type of claim electronically;
- Disability of all members of a health care professional or supplier's staff prevents use of a computer for electronic submission of claims; and
- Other rare situations that cannot be anticipated by the Centers for Medicare & Medicaid Services (CMS) where a health care professional or supplier can establish that due to conditions outside of their control, it would be against equity and good conscience for CMS to enforce this requirement.

Requests for this type of waiver must be sent by letter to the Medicare Contractor. Visit *http://www.cms.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp* for more information.

Note that Medicare Secondary Payer (MSP) claims submission is not an exception to mandatory electronic claims submission unless there is more than one primary payer to Medicare.

Revised Form CMS-1500 (08/05)

The Form CMS-1500 is maintained by the National Uniform Claim Committee (NUCC).

The NUCC updated the Form CMS-1500 to accommodate the National Provider Identifier (NPI), a unique provider number mandated by HIPAA.

The revised form is designated as Form CMS-1500 (8/05) and was developed through a collaborative effort led by NUCC, in consultation with CMS. **The Form CMS-1500 (08/05) is the only version now accepted by Medicare.**

Visit *http://www.nucc.org/images/stories/PDF/change_log.pdf* for a complete listing of changes made to the Form CMS-1500 (08/05).

Crosswalk of Paper Form CMS-1500 Fields to Electronic Form Equivalent Fields

The Accredited Standards Committee (ASC) X12N 837 Professional is the standard format for transmitting health care claims electronically. The NUCC has developed a crosswalk between the (ASC) X12N 837 Professional and the Form CMS-1500 located at *http://www.nucc.org* on the web. Medicare Carriers, A/B MACs, and DME MACS may also include a crosswalk on their websites.

Purchasing the Form CMS-1500

Health care professionals and suppliers are responsible for purchasing their own claim forms. The Form CMS-1500 is available in single, multipart snap-out sets or in continuous pin-feed formats and may be obtained from the United States Government Printing Office (GPO). Contact the GPO at 1-202-512-1800 or visit *http://bookstore.gpo.gov* on the Internet. It is also available from printing companies and office supply stores, as long as it follows the CMS approved specifications. These specifications may be found in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 26, Section 30) at *http://www.cms.gov/manuals/downloads/clm104c26.pdf* on the CMS website.

You may download a sample of the revised form by visiting *http://www.cms.gov/CMSForms/CMSForms/list.asp* on the CMS website. Under the search options, select "Show only items containing the following word" and enter "CMS 1500" in the corresponding field. Then, select the "Show Items" button to locate the form.

Completing the Form CMS-1500

Since most paper claims submitted to Medicare are electronically read using Optical Character Recognition (OCR) equipment, the only acceptable claim forms are those printed in OCR Red, J6983, (or exact match) ink.

Claims submitted on forms that cannot be read by the OCR equipment will be returned. Claims must be submitted as originals. Photocopied claims are not accepted.

Form CMS-1500 completion instructions, as well as the print specifications, may be found in the *Medicare Claims Processing Manual* at *http://www.cms.gov/manuals/downloads/clm104c26.pdf* on the CMS website.

Visit the NUCC *1500 Health Insurance Claim Form Reference Instruction Manual* at *http://www.nucc.org/images/stories/PDF/claim_form_manual_v3-0_7-07.pdf* for additional information.

Note that some payers may give different instructions on how to complete certain Item Numbers on the claim form.

Health care professionals and suppliers should always refer to the most current Federal, State, or other payer instructions for specific requirements applicable to using the Form CMS-1500. Health care professionals and suppliers should always confirm that payers accept claim forms with pre-printed information.

Timely Filing

The timely filing period for both paper and electronic Medicare claims for services furnished on or after January 1, 2010, is 1 calendar year after the date of service. Claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

Claims will be denied if they arrive after the deadline date. When a claim is denied for having been filed after the timely filing period, such a denial does not constitute an "initial determination." As such, the determination that a claim was not filed timely is not subject to appeal.

Claim Errors

"Unprocessable claims" is a term used by Medicare for claims that contain certain incomplete or invalid information and are returned to the provider. For example, a claim may be returned as unprocessable because the contractor requires additional information or a correction to the submitted claim data. Because there is no initial determination on the claim, health care professionals and suppliers who submit unprocessable claims have no appeal rights.

The phrase "return as unprocessable" does not mean that in every case a claim is physically returned. Contractors may return the actual unprocessable claim (or a copy of it) to the health care professional or supplier with a letter of explanation or generate a Remittance Advice (RA), which we will discuss later in this fact sheet. Some contractors may suspend a claim that contains incomplete or invalid information, and then provide notice of the errors to the provider and afford a period of time for corrections to be submitted. When adequate corrections are submitted, the contractor will then resume processing of the claim.

Providers need to be aware that an unprocessable claim that has been returned for correction and resubmission does not toll the timely filing period. A correct claim must be resubmitted within the timely filing period. Where a contractor has suspended a claim and allowed a period for submission of corrections, the timely filing requirements will have been met if the corrections are received within the allotted time.

Form CMS-1500 incomplete and invalid claims processing guidelines may be found in the *Medicare Claims Processing Manual* at *http://www.cms.gov/manuals/downloads/clm104c01.pdf* starting at Section 80.3.1.

Tips for submitting error-free paper claims

TROUBLESHOOTING BASICS:

- Use only an original red-ink-on-white-paper Form CMS-1500 claim form.
- Use dark ink.
- Do not print, hand-write, or stamp any extraneous data on the form.
- Do not staple, clip, or tape anything to the Form CMS-1500 claim form.
- Remove pin-fed edges at side perforations.
- Use only lift-off correction tape to make corrections.
- Place all necessary documentation in the envelope with the Form CMS-1500 claim form.

FORMAT HINTS:

- Do not use italics or script.
- Do not use dollar signs, decimals, or punctuation.
- Use only upper-case (CAPITAL) letters.
- Use 10- or 12-pitch (pica) characters and standard dot matrix fonts.
- Do not include titles (e.g., Dr., Mr., Mrs., Rev., M.D.) as part of the beneficiary's name.
- Enter all information on the same horizontal plane within the designated field.
- Follow the correct Health Insurance Claim Number (HICN) format. No hyphens or dashes should be used. The alpha prefix or suffix is part of the HICN and should not be omitted. Be especially careful with spouses who have a similar HICN with a different alpha prefix or suffix.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Use an individual's name in the provider signature field, not a facility or practice name.

ACCURATE INFORMATION IS KEY:

- Put the beneficiary's name and Medicare number on each piece of documentation submitted. Always use the beneficiary's name exactly as it appears on the beneficiary's Medicare card.
- Include all applicable NPIs on the claim, including the NPI for the referring provider.
- Indicate the correct address, including a valid ZIP code, where the service was rendered to the beneficiary. Any missing, incomplete, or invalid information in the Service Facility Location Information field will cause the claim to be unprocessable. Any claims received with the word "SAME" in fields indicating that the information is the same as in another field are unacceptable. A post office box address is unacceptable in the field for the location where the service was rendered.
- Include special certification numbers for services such as mammography (FDA number) and clinical laboratory (CLIA number).
- Ensure that the number of units/days and the date of service range are not contradictory.
- Ensure that the number of units/days and the quantity indicated in the procedure code's description are not contradictory.

CODING TIPS:

- Use current valid diagnosis codes and code them to the highest level of specificity (maximum number of digits) available. Also make sure that the diagnosis codes used are appropriate for the gender of the beneficiary.
- Use current valid procedure codes as described in the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) manuals.
- Use only Level II HCPCS codes, not local codes.
- Use current valid modifiers when necessary.

More Troubleshooting Tips…

Item 11: If Medicare is the primary payer, enter the word "None" in Item 11. If Medicare is not the primary payer, include the primary payer's information and a copy of the primary payer's Explanation of Benefits or Remittance Advice.

Item 17: Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Remittance Advice

After a claim has been received and processed, the Medicare contractor sends the health care professional or supplier a notice of payments and adjustments explaining the reimbursement decisions including the reasons for adjustments of processed claims. This notice is called a Remittance Advice (RA).

The RA may serve as a companion to a claim payment or as an explanation when there is no payment. The explanation of the errors will be provided in the form of a description or a code.

Note that unprocessable claims returned with a Remittance Advice can be identified by the presence of code MA130 and an explanation of the specific rejection reason.

For more information on Remittance Advice, visit *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* on the CMS website.

Web Resources

***Medicare Claims Processing Manual* (Pub. 100-04, Chapter 26)**
http://www.cms.gov/manuals/downloads/clm104c26.pdf

Electronic Billing & EDI Transactions – Professional Paper Claim Form (CMS-1500) Web Page
http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp

National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual
http://www.nucc.org/images/stories/PDF/claim_form_manual_v3-0_7-07.pdf

Administrative Simplification Compliance Act
http://www.cms.gov/HIPAAGenInfo/Downloads/ASCALaw.pdf

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals
http://www.cms.gov/MLNProducts/downloads/physicianguide.pdf

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers
http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

Form CMS-1500 Web-based Tutorial
http://www.cms.gov/MLNEdWebGuide

CMS Electronic Mailing Lists
http://www.cms.gov/AboutWebsite/EmailUpdates/list.asp

Medicare Learning Network (MLN) Website
http://www.cms.gov/MLNGenInfo

MLN Matters Articles
http://www.cms.gov/MLNMattersArticles

Carrier & A/B MAC Contact Information
http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip

Looking for the latest online educational resources?
Visit the Medicare Learning Network (MLN) at *http://www.cms.gov/MLNGenInfo* on the CMS website.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

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. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID 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 Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.