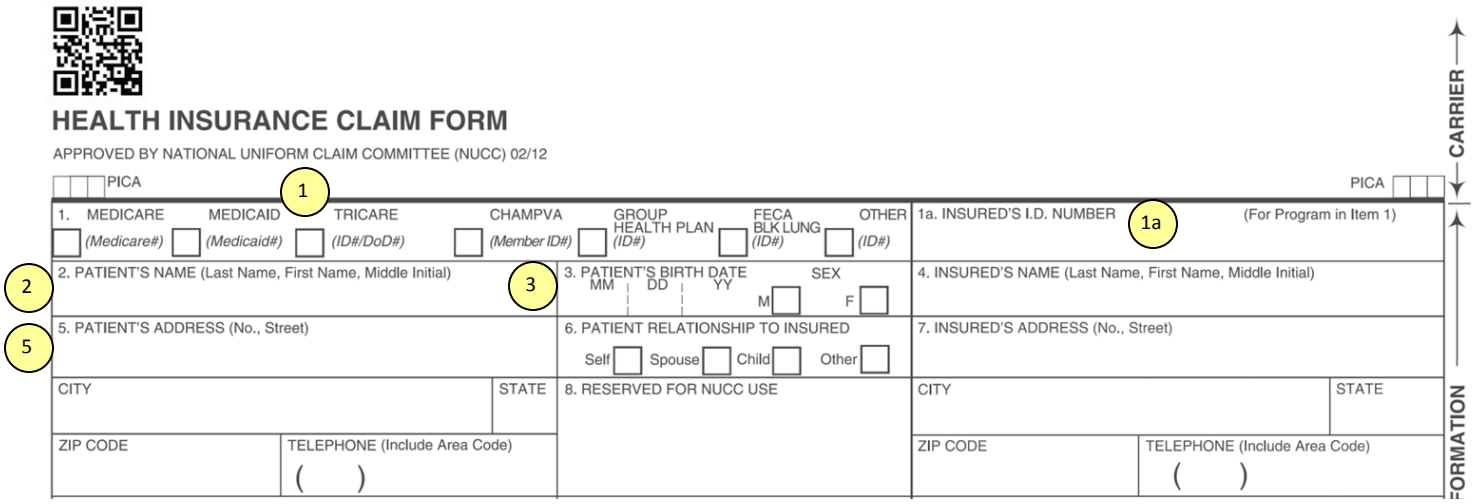
CMS-1500 Completion Guide (version 02/12)



HEALTH INSURANCE CLAIM FORM

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

PICA 1 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 1a (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2			3. PATIENT'S BIRTH DATE MM DD YY 3 SEX M F				4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 5			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) ( )

CARRIER

FORMATION

#	Field Name	Field Instructions
1	Health Insurance Coverage	Show all types of coverage applicable to this claim by checking the appropriate box(es). If Group Health Plan is checked and the patient has only one primary health insurance policy, complete either block 9 (fields 9, 9a, and 9d) **or** block 11 (fields 11, 11b, and 11c). If the beneficiary has two policies, complete both blocks, one for each policy. **IMPORTANT**: Check the "MEDICAID" field at the top of the form.
1a	Insured's ID Number	Enter the patient's Medicaid ID number, exactly as it appears on the South Carolina Healthy Connections Medicaid card (10 digits, no letters).
2	Patient's Name	Enter the patient's last name, first name, and middle initial.
3	Patient's Birth Date Sex	Enter the date of birth of the patient written as month, day, and year. Check "M" for male or "F" for female.
5	Patient's Address	Enter the full address and telephone number of the patient.

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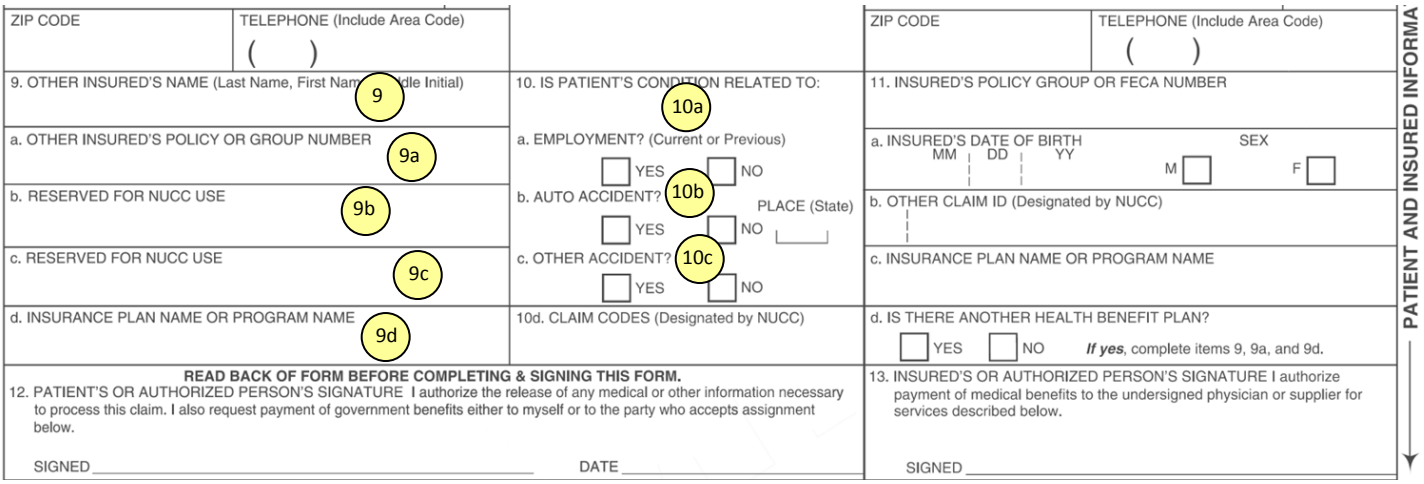

#	Field Name	Field Instructions	
9	Other Insured's Name	When applicable, enter the name of the other insured. If 11d is marked "YES," complete fields 9, 9a, and 9d.	
9a	Other Insured's Policy or Group Number	When applicable, enter the policy or group number of the other insured.	
9b	Reserved for NUCC Use	When applicable, enter the date of birth of the other insured.	
9c	Reserved for NUCC Use	If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	
9d	Insurance Plan Name or Program Name	When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.	
10	Is Patient's Condition Related to:	Check "Yes" or "No" in the fields below.	
		10a	Employment?
		10b	Auto Accident? *If "YES," enter the two-character state postal code in the Place (State) field (e.g., "SC")*
		10c	Other Accident?

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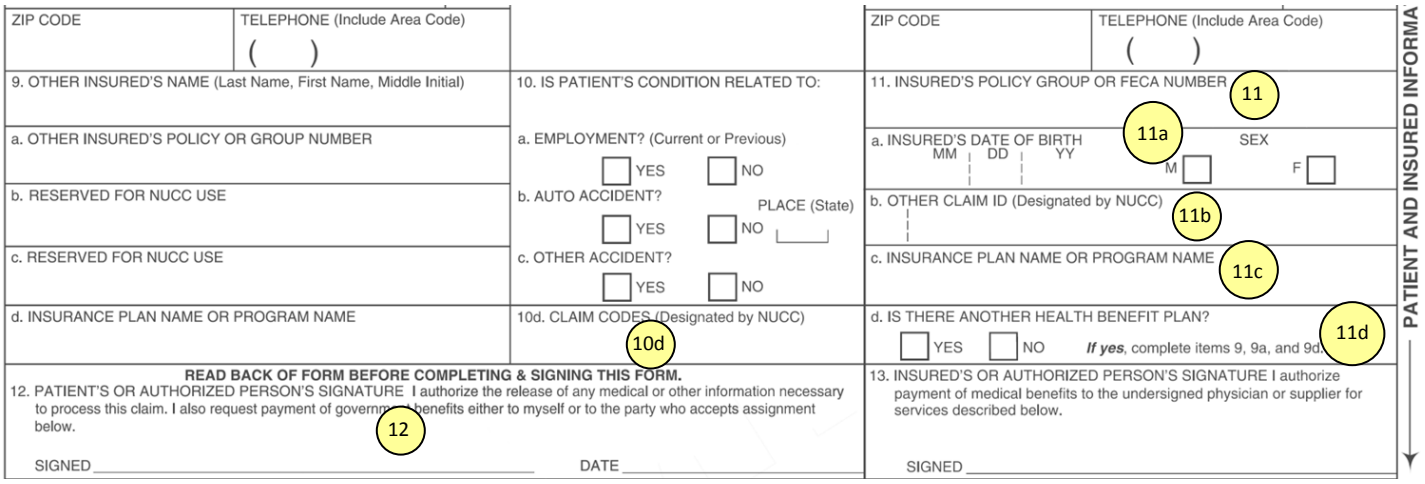

#	Field Name	Field Instructions
10d	Claim Codes (Designated by NUCC)	When applicable, enter the appropriate TPL indicator for this claim. Valid indicators are as follows: **1**-Insurance denied, **6**-Crime victim, **8**-Uncooperative beneficiary
11	Insured's Policy Group or FECA Number	If the beneficiary is covered by health insurance, enter the insured's policy number.
11a	Insured's Date of Birth Sex	When applicable, enter the insured's date of birth. Check "M" for male or "F" for female.
11b	Other Claim ID (Designated by NUCC)	If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field. **The payment information should be entered on the right-hand side of the vertical, dotted line.**
11c	Insurance Plan Name or Program Name	When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.
11d	Is There Another Health Benefit Plan?	Check "YES" or "NO" to indicate whether or not there is another health insurance policy. If "YES," items 9, 9a, and 9d **or** 11, 11b, and 11c must be completed. (If there are two policies, complete both.)
12	Patient's or Authorized Person's Signature	"Signature on File" or patient's signature is required.

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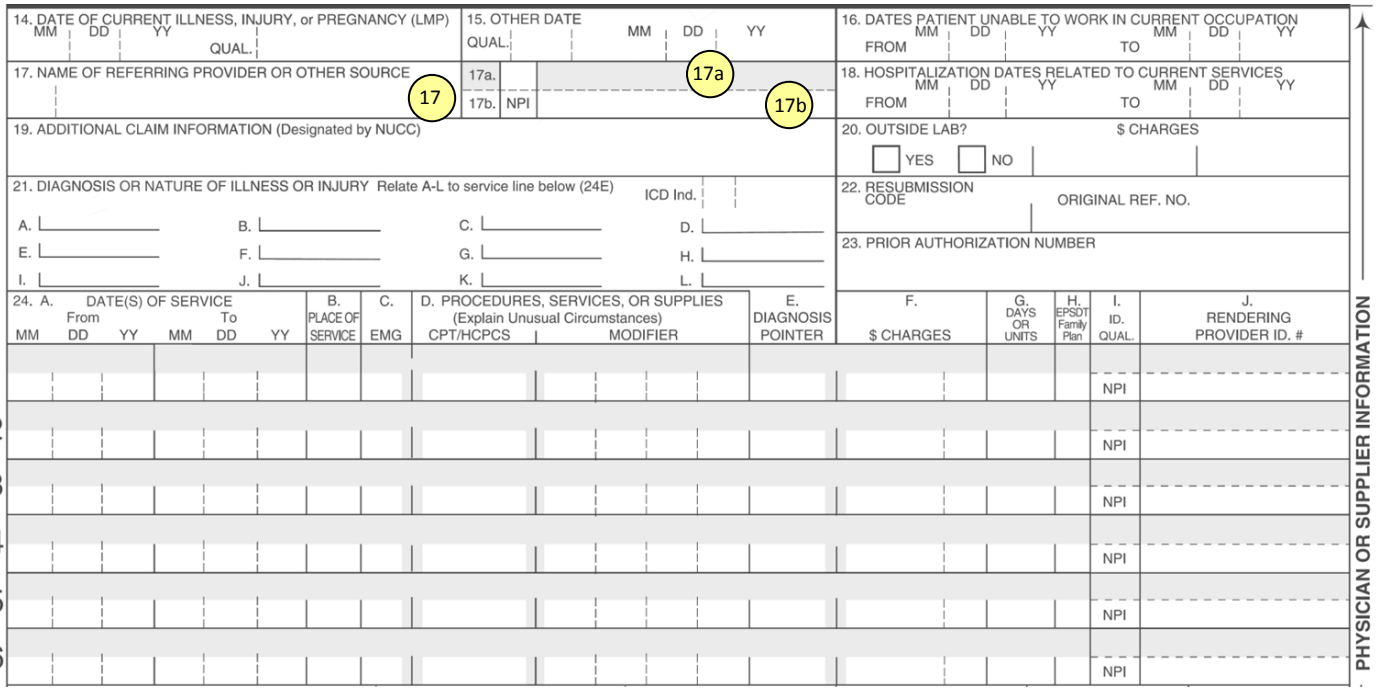

#	Field Name	Field Instructions		
17	Name of Referring Provider or Other Source	Fields 17, 17a, and 17b are used to enter the referring, ordering, and/or supervising provider(s). Field values are a combination of a two-byte qualifier followed by the NPI of the applicable provider. Valid qualifiers are DN = Referring; DK = Ordering; DQ = Supervising.	17	Enter the two-byte qualifier to the left of the vertical, dotted line. Enter the name of the referring, ordering, or supervising provider to the right of the vertical, dotted line.
			17a **Shaded**	Enter the provider's license number if applicable.
			17b **Unshaded** **NPI**	Enter the NPI of the referring, ordering, or supervising provider listed in field 17.

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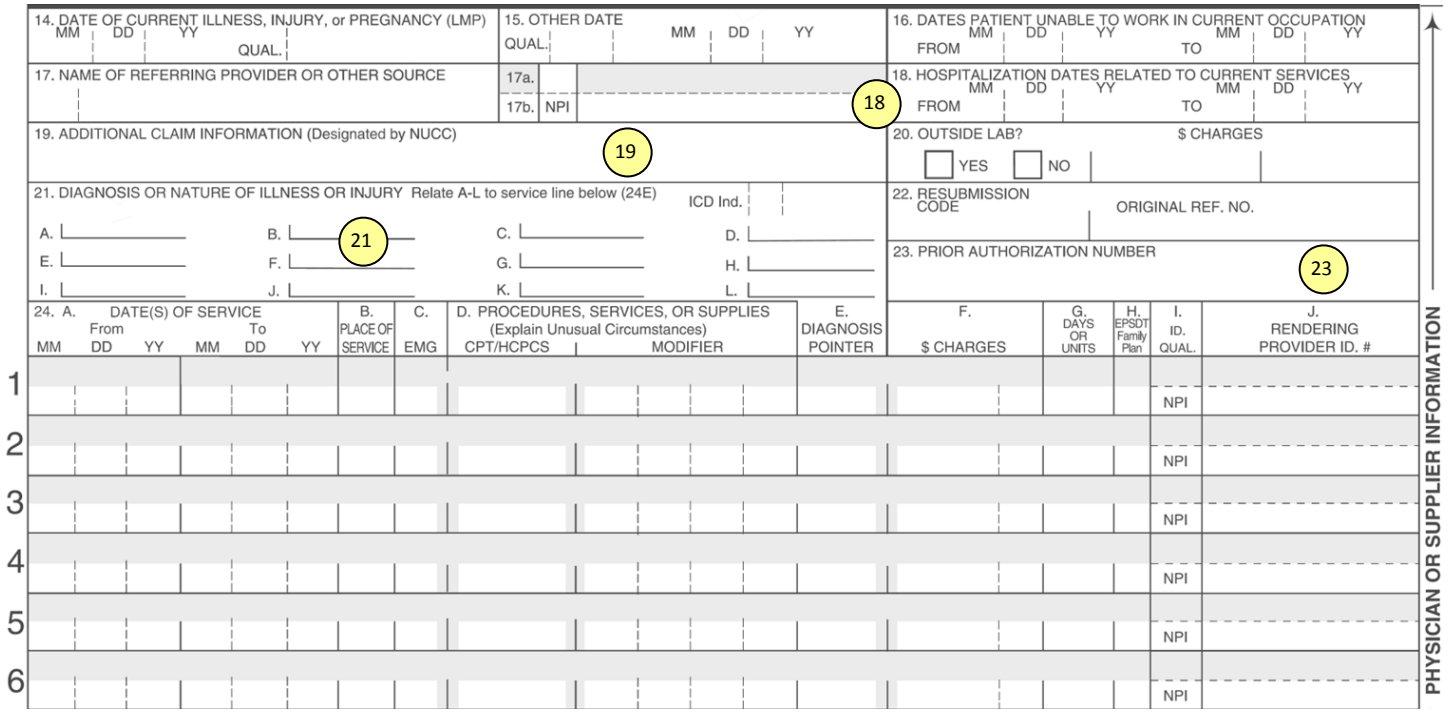

#	Field Name	Field Instructions
18	Hospitalization Dates Related to Current Services	Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information (Designated by NUCC)	For beneficiaries participating in special programs (*i.e.*, CLTC, Medical Homes, Hospice, etc.), enter the primary care provider's referral number.
21	Diagnosis or Nature of Illness or Injury	**ICD Ind.** Not applicable **Diagnosis Codes** Enter the diagnosis codes of the patient as indicated in the ICD-9-CM, Volume I. SC Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code. Enter the diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.
23	Prior Authorization Number	If applicable, enter the prior authorization number for this claim.

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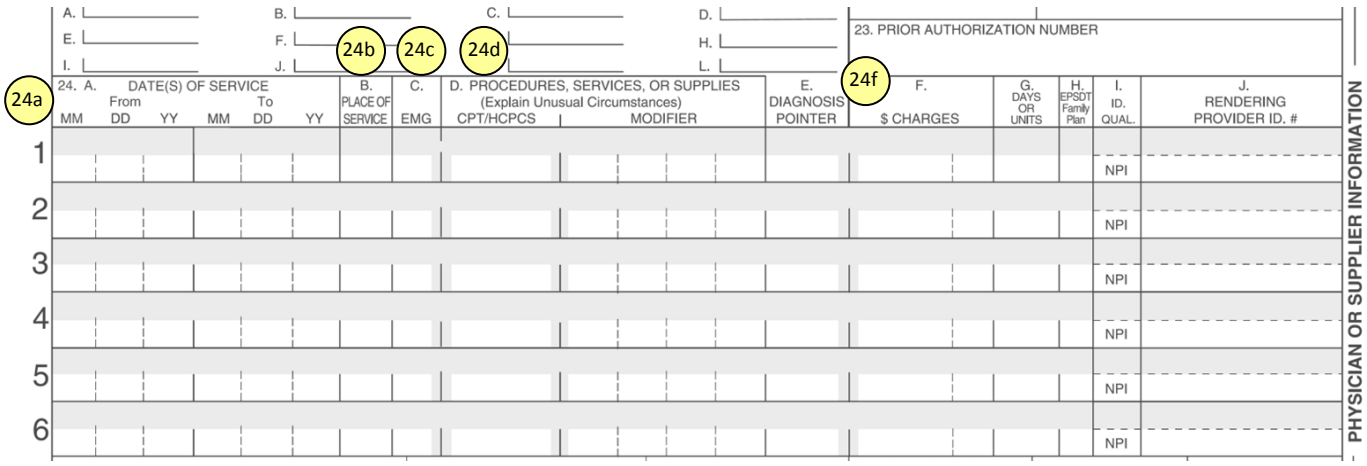

#	Field Name	Field Instructions	
24a	Date(s) of Service	Shaded	**NDC Qualifier/NDC Number** If applicable, enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.
		Unshaded	**Date(s) of Service** Enter the month, day, and year for each procedure, service, or supply that was provided.
24b	Place of Service	Unshaded	Enter the appropriate two-character place of service code.
24c	EMG	Unshaded	If applicable, enter an "E" in this field to indicate that the service rendered was on an emergency basis.
24d	Procedures, Services, or Supplies	Unshaded	Enter the procedure code and, if applicable, the two-character modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim. When more than one service of the same kind is rendered to the same patient by the same provider on the same day, the second service must be billed with the 76 modifier (repeat procedure – same day provider). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.
24f	Charges	Unshaded	Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter "00" in the cents area if the amount is a whole number.

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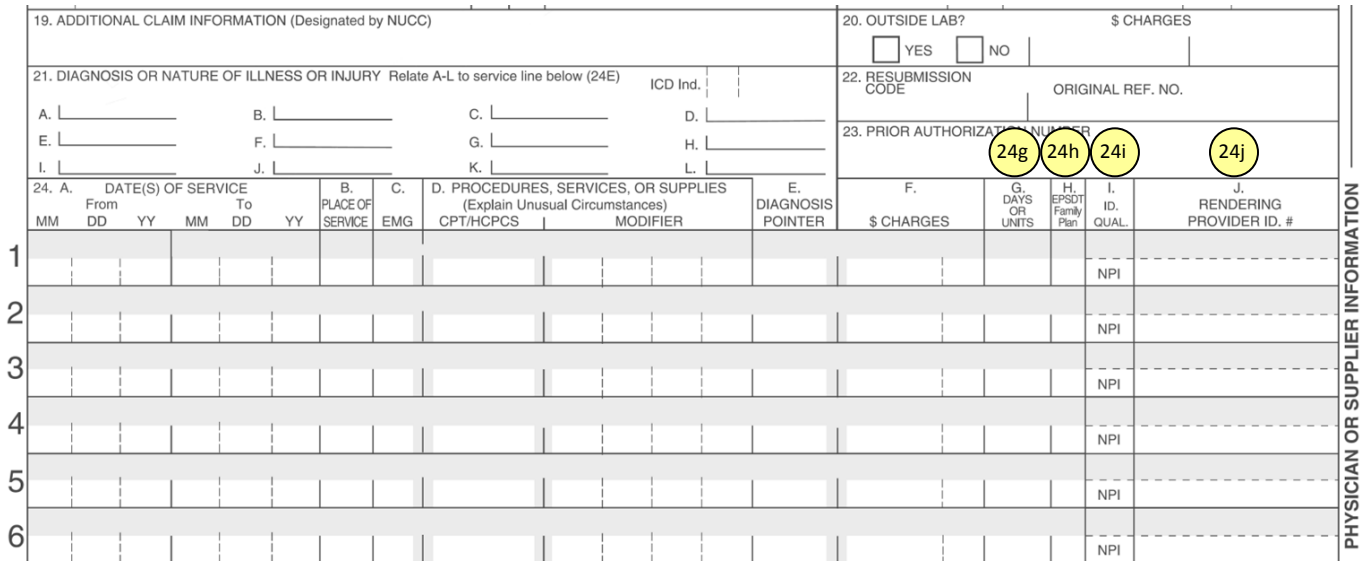

#	Field Name		Field Instructions
24g	Days or Units	Unshaded	If applicable, enter the number of days or units provided for each procedure listed.
24h	EPSDT/Family Plan	Unshaded	If applicable, if this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y." This field should be coded as follows: N = No problems found during visit, 1 = Well child care with treatment of an identified problem treated by the physician, 2 = Well child care with a referral made for an identified problem to another provider
24i	ID Qualifier	Shaded	**Typical Providers**: Enter ZZ for the taxonomy qualifier. **Atypical Providers**: Enter 1D for the Medicaid qualifier.
24j	Rendering Provider ID #	Shaded	Enter the six-character legacy Medicaid provider number or taxonomy code of the rendering provider/individual who performed the service(s). **Typical Providers**: Enter the provider's taxonomy code. **Atypical Providers**: Enter the six-character legacy Medicaid provider number.
		Unshaded	**Typical Providers**: Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. **Atypical Providers**: Not applicable

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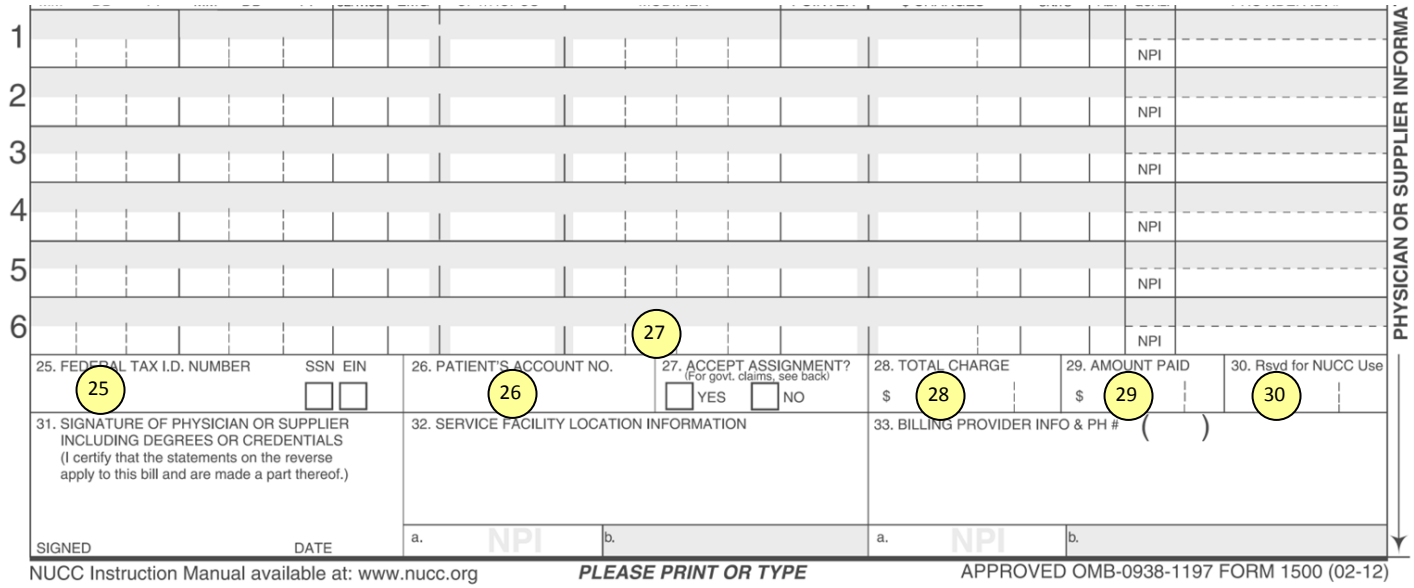

#	Field Name	Field Instructions
25	Federal Tax ID Number	Enter the provider's federal tax ID number (Employer Identification Number) or Social Security Number.
26	Patient's Account Number	Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.
27	Accept Assignment?	Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.
28	Total Charge	Enter the total charge for the services.
29	Amount Paid	If applicable, enter the total amount paid from all insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.
30	Rsvd for NUCC Use	Enter the balance due. When a beneficiary has third party coverage, including Medicare, this is where the patient responsibility amount is entered. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer, including Medicare.

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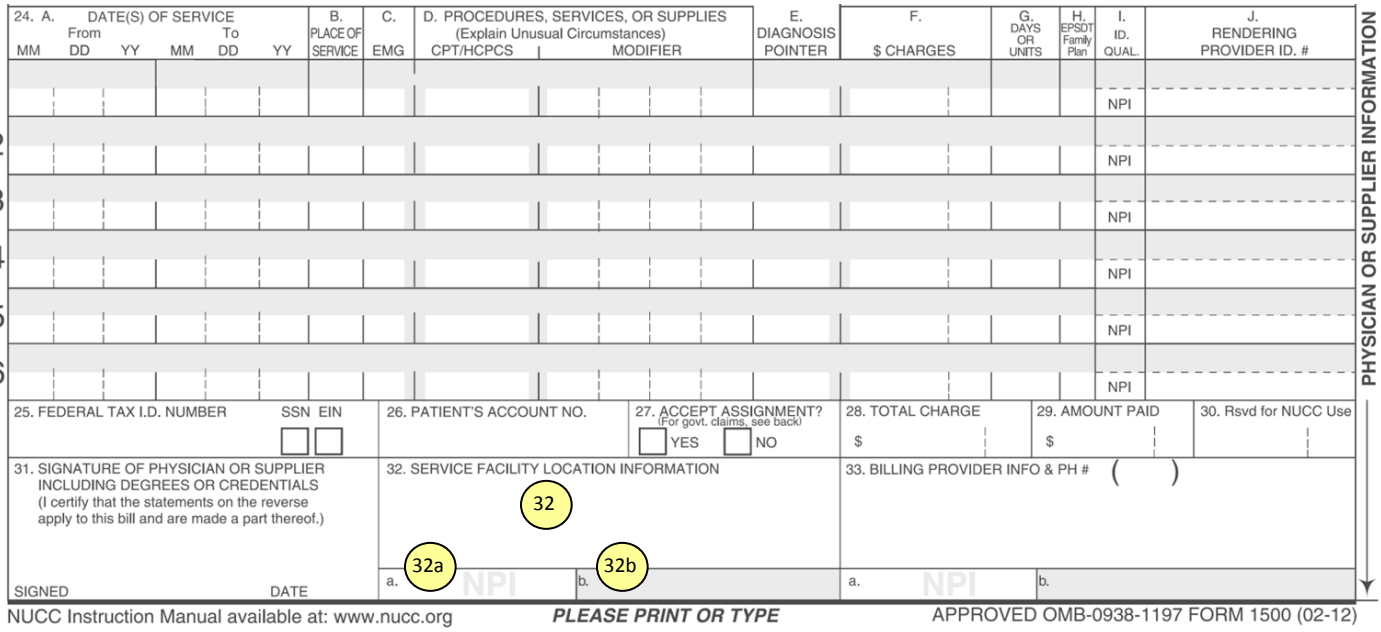

#	Field Name		Field Instructions
32	Service Facility Location Information	32	**Note**: Use field 32 only if the address is different from the address in field 33. If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in a facility other than the patient's home or provider's office.
		32a	**Typical Providers**: Enter the NPI of the service facility. **Atypical Providers**: Not applicable
		32b	**Typical Providers**: Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces). **Atypical Providers**: Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

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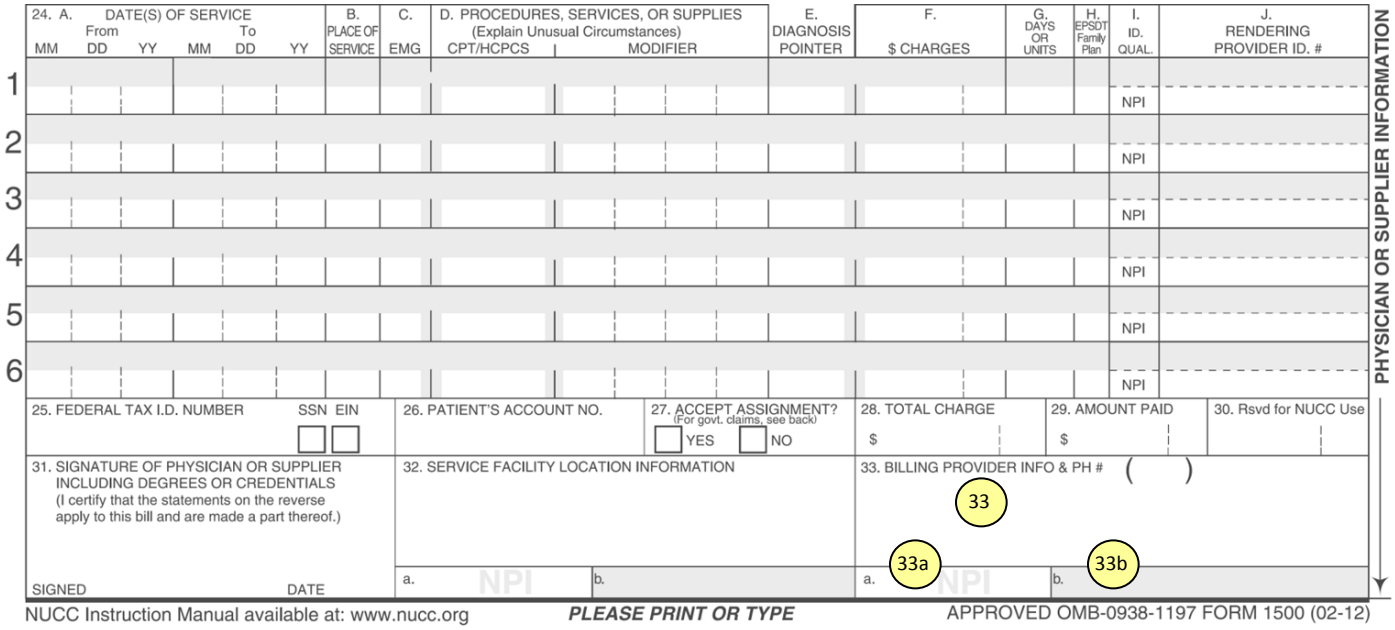

#	Field Name	Field Instructions	
33	Billing Provider Info & PH #	33	Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number. **Note**: Do not use commas, periods, or other punctuation in the address. When entering a ZIP+4 code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and payment.
		33a	**Typical Providers**: Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member of a group, enter the 10-character individual NPI in the field. **Atypical Providers**: Not applicable
		33b	**Typical Providers**: Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces). **Atypical Providers**: Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).