

Tips for Completing the CMS-1500 Claim Form

Field Number	Field Description	Data Type	Instructions
Member Information (Fields 1-13)			
1	Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box (e.g., if a Medicare claim is being filed, check the Medicare box).
1a	Insured's ID number	Required	List the Insured's identification number here. Verify that the identification number corresponds to the insured listed in item 4. The patient and the insured are not always the same person. Some payers assign unique identification numbers to each enrollee or dependent and require the number of the enrollee or dependent receiving services (the patient) instead of the insured's number in this item.
2	Patient's name	Required	Enter the patient's last name, first name, and middle initial, if any. NOTE: If the patient has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. Do not use any punctuation in this field.
3	Patient's birth date and gender	Required	Enter the patient's birth date and sex. Use the eight digit format (MM DD CCYY) format for date of birth. Enter an X in the correct box to indicate the sex of the patient. Only one box can be marked. If the gender is unknown, leave blank.
4	Insured's name	Required	Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name.
5	Patient's address, city, state, zip code and telephone number	Required	Enter the patient's mailing address and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number. NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.

Field Number	Field Description	Data Type	Instructions
6	Patient's relationship to the insured	Required	Check the appropriate box for the patient's relationship to the insured when item 4 is completed. Remember that the patient's relationship to the insured is not always "self".
7	Insured's address, city, state, zip code and telephone number	Required	Enter the insured's address (apartment/PO box number, street, city, state, zip code and telephone number with area code). When the address is the same as the patient's enter the word "same". Complete this item only when items 4 and 11 are completed. NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.
8	Patient status	Required	Check the appropriate box for the patient's marital status and whether employed or a student.
9	Other insured's name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.
9a	Other insured's policy or group number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.
9b	Other insured's date of birth	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.
9c	Other insured's employer's name or school name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.

Field Number	Field Description	Data Type	Instructions
10a - c	Is the patient's condition related to: <ul style="list-style-type: none"> • Employment? • Auto accident? • Other accident? 	Required	Place an "X" in the box indicating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.
10d	Reserved for local use	Not required	Please leave blank.
11	Insured's policy group or FECA number	Optional	Enter the Insured's policy or group number as it appears on the insured's health care identification card.
11a	Insured's date of birth and sex	Conditional	Required if the patient is not the insured. Enter the insured's eight-digit birth date in the MMDDCCYY format and sex if different from item 3.
11b	Employer name or school name	Conditional	Enter the insured's employer's name, if applicable. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name.
11c	Insurance plan name or program name	Conditional	Enter the insured's insurance company or program name.
11d	Is there another health benefit plan?	Required	Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.
12	Patient's or authorized person's signature (Medicaid/other information release)	Conditional	The patient <i>must</i> sign and date the claim <i>if</i> authorizing the release of medical information. If "signature on file" is indicated, the provider <i>must</i> maintain a signed release form or CMS-1500 (formally HCFA 1500). The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.

Field Number	Field Description	Data Type	Instructions
13	Insured's or authorized person's signature	Conditional	The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature are acceptable. If there is no signature on file leave this item blank or enter "no signature on file".
Provider of Service or Supplier Information (Fields 14-33)			
14	Date of current illness, injury or pregnancy	Not required	Not applicable.
15	If patient has had same or similar illness, give first date	Not required	Not applicable.
16	Dates patient unable to work in current occupation	Conditional	Required if the patient is eligible for disability or worker's compensation benefits due to this illness. Enter the "From" and "To" dates the patient was unable to work in MMDDYY or MMDDCCYY format.
17	Name of referring physician or other source	Conditional	Enter the name of the referring physician or other source if applicable.

Field Number	Field Description	Data Type	Instructions
17a	ID number of referring physician	Conditional	<p>The CMS-assigned UPIN of the referring or ordering physician listed in Field 17. Enter only the seven-digit base number and the one-digit check digit.</p> <p>NOTE: The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available.</p> <p>The other ID number of the referring provider, ordering provider, or other source should be reported in 17a in the shaded area. The qualifier indicating what the number represents should be reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:</p> <ul style="list-style-type: none"> • 0B – State license number • 1B – Blue Shield provider number • 1C – Medicare provider number • 1D – Medicaid provider number • 1G – Provider UPIN number • 1H – CHAMPUS identification number • EI – Employer’s identification number • G2 – Provider commercial number • LU – Location number • N5 – Provider plan network identification number • SY – Social Security number (The Social Security number may not be used for Medicare) • X5 – State industrial accident provider number • ZZ – Provider taxonomy – A list of the valid Taxonomy codes begins on Page 38.
17b	NPI	Required	<p>Enter the NPI of the referring or ordering physician listed in item 17 as soon as it is available. The NPI may be reported as of October 1, 2006.</p> <p>NOTE: Field 17a and / or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.</p>

Field Number	Field Description	Data Type	Instructions
18	Hospitalization dates related to current services	Conditional	Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.
19	Reserved for local use	Conditional	If billing for intensive outpatient programs, please write "IOP" in this space.
20	Outside lab/charges	Conditional	Enter if lab tests performed and billed on this claim were processed by a lab outside the provider's premises.
21.1-4	Diagnosis or nature of illness or injury	Required	Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.)
22	Medicaid resubmission code/original reference number	Conditional	List the original reference (claim) number for resubmitted claims.
23	Prior authorization number	Not required	Not applicable.
24a	Dates of service	Required	Enter "From" and "To" dates of service in MMDDYY or MMDDCCYY format. Line items can include no more than two dates of service for the same procedure code. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column C.
24b	Place of service	Required	Enter the appropriate place of service code from the list provided beginning on Page 19.
24c	EMG	Not required	Not applicable.
24d	Procedures, services or supplies CPT/HCPCS	Required	Enter a valid CPT or HCPCS code for each service rendered.

Field Number	Field Description	Data Type	Instructions
24d	Modifier	Conditional	<p>Enter a valid CPT or HCPCS code modifier for each service entered.**</p> <p><u>HIPAA: Billing Code Modifiers</u></p> <p>** When submitting a CPT or HCPC code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below:</p> <p>Modifier ONE: This field is dedicated for modifiers that affect or define the service (e.g., TG modifier to identify a ‘complex high level of care’)</p> <p>Modifier TWO: This field is dedicated for modifiers that identify pricing (e.g., HA modifier to identify ‘child/adolescent’ or HN modifier to identify ‘bachelors level’)</p> <p>Modifier THREE & FOUR: These fields are dedicated for modifiers that identify statistics (e.g., HV ‘funded by State Addictions Agency’)</p> <p>If you have any questions regarding the placement of Modifiers, please contact your Regional Provider Relations office for instructions.</p>
24e	Diagnosis pointer	Conditional	<p>Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, either a 1, 2, 3 or 4, is shown. <i>Do not</i> enter the ICD-9 diagnosis code.</p>
24f	Charges	Required	<p>Enter the provider’s billed charges for each service.</p>
24g	Days or units	Required	<p>Enter the appropriate number of units or days that correspond to the “From” and “To” dates indicated in Field 24a.</p>
24h	EPSDT family plan	Conditional	<p>If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.</p>

Field Number	Field Description	Data Type	Instructions
24i	ID Qual.	Conditional	If the provider does not have an NPI, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24j	Rendering Provider ID.#	Required	Enter the NPI number in the un-shaded area of the field.
25	Federal Tax ID number and type: <ul style="list-style-type: none"> • Social Security Number or • Employer Identification Number 	Required	Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered.
26	Patient's account number	Optional	Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher.
27	Accept assignment?	Required	Enter an "X" in the appropriate box.
28	Total charge	Required	Enter the total charge for this claim. This is the total of all charges for each service noted in Field 24f.
29	Amount paid	Conditional	Enter the total amount paid by the patient for services billed on this claim.
30	Balance due	Conditional	Enter the total balance due for the services less any amount entered in Field 29.
31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician or supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care <i>must</i> sign and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter name and address where services are rendered.
32a	a.	Required	Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.
32b	b.	Not Required	Not Applicable
33	Physician's/supplier's billing: name, address, zip code and phone number	Required	Enter the appropriate billing information.

Field Number	Field Description	Data Type	Instructions
33a	PIN number	Required	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.
33b	Group number	Not Required	Not Applicable after May 23, 2007

Place of Service Codes (Field 24B)

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09-10	Unassigned	N/A

Place of Service Code(s)	Place of Service Name	Place of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than a psychiatric facility, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Place of Service Code(s)	Place of Service Name	Place of Service Description
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

Place of Service Code(s)	Place of Service Name	Place of Service Description
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A

Place of Service Code(s)	Place of Service Name	Place of Service Description
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, or orthotic and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.