

Tips for Completing the CMS-1500 Claim Form
FAILURE TO PROVIDE VALID INFORMATION MATCHING
THE INSURED'S ID CARD COULD RESULT IN A REJECTION
OF YOUR CLAIM.

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. THIS MUST MATCH THE ID ON THE INSURED'S IDENTIFICATION CARD. 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. THIS MUST MATCH THE NAME ON THE INSURED'S IDENTIFICATION CARD

Field Number	Field Description	Data Type	Instructions
5	Patient's address, city, state, zip code and telephone number	Required	<p>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.</p> <p>NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 North Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.</p>
6	Patient's relationship to the insured	Required	<p>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".</p>
7	Insured's address, city, state, zip code and telephone number	Required	<p>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.</p> <p>NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 North Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.</p>
8	Patient status	Conditional	<p>Check the appropriate box for the patient's marital status and whether employed or a student.</p>
9	Other insured's name	Conditional	<p>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.</p>
9a	Other insured's policy or group number	Conditional	<p>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.</p>

Field Number	Field Description	Data Type	Instructions
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.
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.

Field Number	Field Description	Data Type	Instructions
12	Patient's or authorized person's signature (Medicaid/other information release)	Required	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.
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, is acceptable. signature.
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>5010A1 Instructions: The NUCC defines the following qualifiers used in 5010A1:</p> <p>0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.)</p> <p>The non-NPI ID number of the referring, ordering, or supervising provider refers to the unique identifier of the professional or to the provider designated taxonomy code. This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.</p> <p style="text-align: center;">•</p>
17b	NPI	Required	<p>Enter the NPI of the referring or ordering physician listed in item 17</p> <p>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>
18	Hospitalization dates related to current services	Conditional	<p>Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.</p>
19	Reserved for local use	Conditional	<p>If billing for intensive outpatient programs, please write "IOP" in this space.</p>
20	Outside lab/charges	Conditional	<p>Enter if lab tests performed and billed on this claim were processed by a lab outside the provider's premises.</p>

Field Number	Field Description	Data Type	Instructions
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. ICD-10 codes to be used when implemented as required by CMS. 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 G.
24b	Place of service	Required	Enter the appropriate place of service code from the list of HIPAA compliant codes provided beginning on Page 9.
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>Modifiers are required where applicable for Medicaid plans. 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 order. 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. . <i>Do not</i> enter the diagnosis code. (Electronic claims will allow up to four reference numbers per line.)</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. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form. Note: This identifier is not included in this data element in 5010A1.)
24j	Rendering Provider ID.#	Conditional	Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.
25	Federal Tax ID number and type: • 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. Do not enter hyphens with numbers. Enter numbers left justified in the field.
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?	Conditional	Enter an "X" in the appropriate box. Required for Government claims (e.g. Medicaid)
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.

Field Number	Field Description	Data Type	Instructions
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. This must be a street address not a P.O. Box.
32a	a.	Required	Enter the NPI of the service facility
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.
33a	PIN number		Enter the NPI of the billing provider or group.
33b			NA

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.

Place of Service Code(s)	Place of Service Name	Place of Service Description
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	Prison – Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
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	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	NOT USED BY	

Place of Service Code(s)	Place of Service Name	Place of Service Description
	ValueOptions	
18-19	Unassigned	N/A
20	NOT USED BY ValueOptions	.
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.
25	NOT USED BY ValueOptions	
26	NOT USED BY ValueOptions	
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.

Place of Service Code(s)	Place of Service Name	Place of Service Description
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.
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.

Place of Service Code(s)	Place of Service Name	Place of Service Description
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
60	NOT USED BY ValueOptions	
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	NOT USED BY ValueOptions	
66-70	Unassigned	N/A

Place of Service Code(s)	Place of Service Name	Place of Service Description
71	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.