CLAIMS FILING

Hard copy billing of professional services are billed on the CMS 1500 claim form. Items to complete are either **situational** or **required. Situational** information may be required in certain circumstances as detailed in the instructions below. **Required** information is needed for the claim to process.

Hard copy claims submitted with missing or invalid information in **required** fields will be returned unprocessed with a rejection letter listing the reason(s) the claim could not be processed. These claims cannot be processed until they are corrected and resubmitted by the provider.

Providers must submit hard copy claims to the fiscal intermediary at

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form
- Sample of CMS 1500 claim form

CMS 1500 (08/05) INSTRUCTIONS FOR PROFESSIONAL SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Situational** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the recipient's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	Patient Status	**Optional.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other insurance coverage, leave blank. If there is other coverage, the Louisiana assigned 6-digit TPL carrier code is **required** in this block. This code is returned through MEVS recipient eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, www.lamedicaid.com. (The carrier code list can be found under the **Forms/Files** link on www.lamedicaid.com). The EOB or EOBs from other insurance(s) must be attached to the hard copy claim.	
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	If Patient Has Had Same or Similar Illness Give First Date	**Optional.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	
17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable. In the following circumstances, entering the name of the appropriate physician is required: • If services are performed by a CRNA, enter the name of the directing physician • If the services are performed by an independent laboratory, enter the name of the referring physician.	
17a	Unlabelled	**Optional.**	
17b	NPI	**Optional.**	
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Reserved for Local Use	Reserved for future use. Do not use.	
20	Outside Lab?	**Optional.**	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description. NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.	The most specific diagnosis codes must be used. General codes are not acceptable
22	Medicaid Resubmission Code	**Optional**.	

Locator #	Description	Instructions	Alerts
23	Prior Authorization Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the PA number is **required** to be entered.	
24	Supplemental Information	Situational - Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, the 11 digit **National Drug Code (NDC)** is required for **physician administered drugs and shall be entered in the shaded section of 24A through 24G.** Claims for these drugs shall include the NDC from the label of the product administered. To report additional information related to HCPCS billed in 24D, providers administering drugs and biologicals must enter the **Qualifier N4** followed by the 11 digit NDC. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space and then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered**. Leave 3 spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers shall be used when reporting NDC units: • F2=International Unit • ML=Milliliter • GR=Gram • UN=Unit	Providers who administer drugs/biologicals must enter drug related information in the SHADED section of 24A-24G of the appropriate detail lines only. This information must be entered in addition to the procedure code(s).
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure billed. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	

Locator #	Description	Instructions	Alerts
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	**Situational** – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter in the un-shaded area(s) the procedure code(s) for services rendered.	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	Usual and customary charges should be entered for the service rendered – not the Medicaid allowable.
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	**Optional.**	
24J	Rendering Provider I.D. #	**Situational** – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is **required**. Entering the Rendering Provider's NPI in the non-shaded portion of the block is **optional**.	
25	Federal Tax I.D. Number	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	

Locator #	Description	Instructions	Alerts
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the other payor (excluding any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional** **Optional**	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	
32b	Unlabelled	**Situational –** Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Required** – Enter the billing provider's 10-digit NPI number	
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit Medicaid ID number.	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (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): **1234567890123**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Lou, Jeannie**

3. PATIENT'S BIRTH DATE: **06 19 85** SEX: M [ ] F [X]

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: **TPL Carrier code if applicable**

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.

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 TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. **V2501** 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	06 02 12	06 02 12	11		99213		1	75 00	1		NPI 1234567 1987654321
2	N401234025003 GR150.00 DEPO-PRO VERA INJ 06 02 12	06 02 12	11		J1055		1	90 00	1		NPI 1234567 1987654321
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: **LOU123456**

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

28. TOTAL CHARGE: $ **165.00**

29. AMOUNT PAID: $

30. BALANCE DUE: $ **165.00**

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.)

JB **Ima Biller** 6/8/12

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Womens Health Clinic
985 Bird Rd
Somewhere, LA 70808

a. **1555555551** b. **1987654**

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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