



4350 E. Cotton Center Boulevard • Building D • Phoenix, AZ 85040 • (602) 263-3000 • (800) 624-3879

Provider Notification

Date of Notification	September 1, 2011	Revision Date	N/A
Plans Affected	All Lines of Business		
Subject	Billing on the CMS 1500 Claim Form		

The following information regarding billing on the CMS 1500 Claim Form is also available on AHCCCS' website under the Fee For Service Provider Manual at:

http://www.azahcccs.gov/commercial/Downloads/FFSProviderManual/FFS_Chap05CMS1500ClaimForm.pdf

INTRODUCTION

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500. CMS-1500 (08/05) version became effective 1/1/2007. Effective April 2, 2007, Mercy Care will accept only this revised version. Minor changes have been made to the form in order to accommodate the National Provider Identifier (NPI) as well as current identifiers for a transition period until NPI is implemented. In order to distinguish this version from the previous versions, the 1500 symbol and the date approved (08/05) by NUCC has been added to the top margin of the claim form.

- CPT and HCPCS procedure codes must be used to identify all services.
- ICD-9 diagnosis codes are required.
 - AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

COMPLETING THE CMS 1500 CLAIM FORM (VERSION (08/05))

The following instructions explain how to complete the CMS 1500 claim form (08/05) and whether a field is “**Required,**” “**Required if Applicable,**” or “**Not Required.**”

NOTE: This Provider Notification applies to paper CMS 1500 claims submitted to Mercy Care. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.azahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.



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1. Carrier Block

Required

The carrier block is located in the upper right margin of the form.

Check the second box labels “Medicaid”.

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)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1a. Insured's ID Number

Required

Enter the recipient's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact Mercy Care’s Member Services Department or view eligibility through MercyOneSource.

1a. INSURED'S I.D. NUMBER A12345678	(For Program In Item 1)
--	-------------------------

2. Patient's Name

Required

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

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

3. Patient's Date of Birth and Sex

Required

Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE	SEX
MM DD YY	M F
01 01 1958	M <input checked="" type="checkbox"/> F <input type="checkbox"/>

4. Insured's Name

Not Required

5. Patient Address

Not Required

6. Patient Relationship to Insured

Not Required

7. Insured's Address

Not Required

8. Patient Status

Not Required



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9. Other Insured's Name

Required if Applicable

If the recipient has no coverage other than Mercy Care, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number

Required if Applicable

Enter the group number of the other insurance.

9b. Other Insured's Date of Birth and Sex

Required if Applicable

If the other insured is not the Mercy Care recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.

9c. Employer's Name or School Name

Required if Applicable

Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

9d. Insurance Plan Name or Program Name

Required if Applicable

Enter name of insurance company or program name that provides the insurance coverage.

10 a - c. Is Patient's Condition Related to:

Required

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:			
a. EMPLOYMENT? (Current or Previous)			
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO		
b. AUTO ACCIDENT? PLACE (State)			
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	<input type="text"/>	
c. OTHER ACCIDENT?			
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO		

10d. Reserved for Local Use

Not Required



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- | | |
|---|-------------------------------|
| 11. Insured's Group Policy or FECA Number | Required if Applicable |
| 11a. Insured's Date of Birth and Sex | Required if Applicable |
| 11b. Employer's Name or School Name | Required if Applicable |
| 11c. Insurance Plan Name or Program Name | Required if Applicable |
| 11d. Is There Another Health Benefit Plan? | Required if Applicable |

Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9a-d.

- | | |
|---|---|
| 12. Patient or Authorized Person's Signature | Not Required |
| 13. Insured's or Authorized Person's Signature | Not Required |
| 14. Date of Current Illness/Injury or Pregnancy | Required if Applicable |
| 15. Date of Same or Similar Illness | Not Required |
| 16. Dates Patient Unable to Work in Current Occupation | Not Required |
| 17. Name of Referring Provider or Other Source | Required if Applicable |
| 17a. ID Number of Referring Provider | <u>(Required only for podiatry services)</u> |
| 17b. NPI # of Referring Provider (shaded area) | <u>(Required only for podiatry services)</u> |
| 18. Hospitalization Dates Related to Current Services | Not Required |
| 19. Reserved for Local Use | Not required |
| 20. Outside Lab? Yes or No and (\$) Charges | Not Required |



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21. Diagnosis Codes

Required

Enter at least one ICD-9 diagnosis code describing the recipient’s condition. Up to four diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			
1.	250 . 00	3.	
2.		4.	

22. Medicaid Resubmission Code

Required if Applicable

Enter the appropriate code (“A” or “V”) to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the Mercy Care Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No.". If the claims is a resubmission or reconsideration, please write “Resubmission” or “Reconsideration” at the top of the claim.

23. Prior Authorization Number

Not Required

The Mercy Care claims system automatically searches for the appropriate authorization for services that require authorization. You may submit the number if you would like.

(24A – I Shaded areas NOT USED)

24A. Date(s) of Service

Required

Enter the beginning and ending service dates.

24. A.	DATE(S) OF SERVICE					
	From			To		
	MM	DD	YY	MM	DD	YY
1	02	01	11	02	01	11

24B. Place of Service Required

Enter the two-digit code that describes the place of service.

- | | | |
|--|---|--|
| 03 School | 22 Outpatient Hospital | 54 ICF/Mentally Retarded |
| 04 Homeless Shelter | 23 ER – Hospital | 55 Residential Substance Abuse Treatment Facility |
| 05 IHS Free-Standing Facility | 24 ASC | 56 Psych Residential Treatment Center |
| 06 IHS Free-Standing Provider Based Facility | 25 Birthing Center | 57 Nonresidential Substance Abuse Treatment Facility |
| 07 Tribal 638 Free-Standing Facility | 26 Military Treatment Facility | 60 Mass Immunization Center |
| 08 Tribal 638 Provider-Based Facility | 31 Skilled Nursing Facility | 61 Comprehensive Inpatient Rehabilitation Facility |
| 11 Office | 32 Nursing Facility | 62 Comprehensive Outpatient Rehabilitation Facility |
| 12 Home | 33 Custodial Care Facility | 65 ESRD Treatment Facility |
| 13 Assisted Living Facility | 34 Hospice | 71 Public Health Clinic |
| 14 Group Home | 41 Ambulance – Land | 72 Rural Health Clinic |
| 15 Mobile Unit | 42 Ambulance – Air or Water | 81 Independent Laboratory |
| 20 Urgent Care Facility | 49 Independent Clinic | 99 Other Place of Service |
| 21 Inpatient Hospital | 50 FQHC | |
| | 51 Inpatient Psych Facility | |
| | 52 Psych Facility – Partial Hospitalization | |
| | 53 Community Mental Health Center | |



24C. EMG – Emergency Indicator

Required if Applicable

Mark this box with a “” an “,” or a “Y” if the service was an emergency service, regardless of where it was provided.



24D. Procedures, Services, or Supplies

Required

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT annuals.



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For some claims billed with CPT/HCPCS codes, modifiers must be used to accurately identify the service provided to avoid delay or denial of payment. Up to 4 modifiers may be entered.

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
CPT/HCPCS	MODIFIER
71010	26

24E. Diagnosis Pointer

Required

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be listed in descending order of importance.

E. DIAGNOSIS POINTER
1

24F. \$ Charges

Required

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.

F. \$ CHARGES
40.00

24G. Days/Units

Required

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and CPCS manuals.

G. DAYS OR UNITS
1



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24H. EPSDT/Family Planning

Not Required

24I. ID Qualifier

Required if Applicable

24J. (SHADED AREA) – Use for COB INFORMATION

Required if Applicable

Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient’ Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount *paid*.

Always attach a copy of the Medicare or other insurer’s EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID #

Required

Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used.

I. ID. QUAL.	J. RENDERING PROVIDER ID. #
NPI	

25. Federal Tax ID Number

Required

Enter the tax ID number and check the box labeled “EIN.” If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN.”

25. FEDERAL TAX I.D. NUMBER	SSN EIN
86-1234567	<input checked="" type="checkbox"/>

26. Patient Account Number

Required if Applicable

This is a number that the provider has assigned to uniquely identify this claim in the provider’s records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider’s own accounting or tracking system.



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27. Accept Assignment

Not Required

28. Total Charge

Required

Enter the total for all charges for all lines on the claim.

28. TOTAL CHARGE	
\$	40 00

29. Amount Paid

Required if Applicable

Enter the total amount that the provider has been paid for this claim by all sources *other than Mercy Care*. Do *not* enter any amounts expected to be paid by Mercy Care.

30. Balance Due

Not required

31. Signature of Physician or Supplier, including degrees and credentials and Date

Required

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

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

Required if Applicable

32a. Service Facility NPI # (non-shaded area) **

Required if Applicable

32b. Service Facility AHCCCS ID # (Shaded Area)

Required if Applicable

32. SERVICE FACILITY LOCATION INFORMATION	
Arizona Hospital 123 Main Street Scottsdale, AZ 89999	
a. NPI ID	b. AHCCCS ID



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33. Billing Provider Name, Address and Phone #

Required

Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI # (non-shaded area) **

Required if Applicable

33b. Other ID – AHCCCS ID # (Shaded Area)

Required if Applicable

33. BILLING PROVIDER INFO & PH # (602) 555-1234	
Arizona Provider 123 Main Street Phoenix, AZ 89999	
a. NPI ID	b. AHCCCS ID

** Note – NPI is required for all providers that are mandated to maintain an NPI number.

For atypical provider types, box 33b must be completed.



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Example: Blank CMS-1500 Form

1500
HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (TRICARE #) CHAMPVA (Member ID) GROUP HEALTH PLAN (Group or ID) FICA (FICA #) OTHER (Other #)

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 RELATIONSHIP TO INSURED (Self Spouse Child Other) 6. EMPLOYER'S NAME OR SCHOOL NAME

7. INSURED'S ADDRESS (No., Street) 8. PATIENT STATUS (Single Married Other) 9. INSURED'S ADDRESS (No., Street) 10. INSURED'S POLICY GROUP OR POLICY NUMBER

11. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F) 12. EMPLOYER'S NAME OR SCHOOL NAME

13. INSURED'S PLAN NAME OR PROGRAM NAME 14. INSURED'S POLICY GROUP OR POLICY NUMBER

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes No) If yes, return to and complete item 3-a-c.

16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: _____ DATE: _____

17. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident OR PREGNANCY) (MM DD YY) 18. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY FIRST DATE (MM DD YY)

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY) 20. OUTSIDE LAB? (Yes No) \$ CHARGES: _____

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Number items 1, 2, 3 or 4 to item 24B by line) 22. MEDICAL PROFESSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE (EMG OPTOMETRIST NURSE) C. PROCEDURE, SERVICES, OR SUPPLIES (Specify unusual circumstances) D. DIAGNOSIS POINTING E. CHARGES (Per get. base service) F. \$ CHARGES G. ORF OR SPTS H. ICD-9 CODE I. QUAL J. RENDERING PROVIDER ID #

25. FEDERAL TAX I.D. NUMBER SSN SIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For get. base service) (Yes No) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (Identify that the statements on the reverse apply to this bill and are made as part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()

SIGNED: _____ DATE: _____ A. _____ B. _____ C. _____ D. _____

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0009 FORM CMS-1500 (08/05)

An editable CMS 1500 form is available on our website under the Forms section.