2.0 CMS-1500 Claim Form Instructions

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the CMS-1500 billing form, and must be used in conjunction with the MS Medicaid Provider Policy Manual. The policy manual and fee schedules should be used as a reference for issues concerning policy and the specific procedures for which Medicaid reimburses. If you have questions, contact the fiscal agent's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222 for assistance.

Provider Types

The instructions for the CMS-1500 claim form are to assist the following categories of provider types:

- Ambulance
- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetists
- Chiropractic Care
- Community Mental Health
- Durable Medical Equipment (DME)
- Federally Qualified Health Centers
- Hearing Aid Providers
- Independent Laboratory
- Independent Radiology
- Mental Health Services
- MS Cool Kids (EPSDT)/ Screening/ Diagnostic Providers
- Nurse Practitioners
- Optical/ Vision Providers
- Perinatal High Risk Management
- Pharmacy Disease Management
- Physicians
- Physician Assistants
- Podiatrists
- Private Duty Nursing
- Rural Health Clinics
- Therapy Services
- Waiver Services

Web Portal Reminder

Providers are encouraged to use the Mississippi Envision Web Portal for easy access to up-to-date information. The web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The web portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at https://msmedicaid.acs-inc.com.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Complete an original CMS-1500 claim form.
- No photocopied claims will be accepted.
- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc. print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- No multiple page claims may be submitted.
- The six service lines in Locator 24 have been divided horizontally to accommodate submission of supplemental information along with NPI and other identifiers such as taxonomy codes or legacy identifiers. The top, shaded portion of each service line is for reporting supplemental information (i.e., NDC code). It is **not** intended to allow the billing of twelve service lines. Each procedure, service, drug, or supply must be listed on its own claim line in the bottom, un-shaded portion of the claim line.

Paper Claims with Attachments

When submitting attachments with the CMS-1500 claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Electronic CMS-1500 Claims

Electronic CMS-1500 claims may be submitted to Mississippi Medicaid by these methods:

- Using the Web Portal Claims Entry feature
- Using WINASAP (free software available from the fiscal agent)
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid.

Electronic CMS-1500 claims must be submitted in a format that is HIPAA compliant with the ANSI X12 CMS-1500 claim standards.

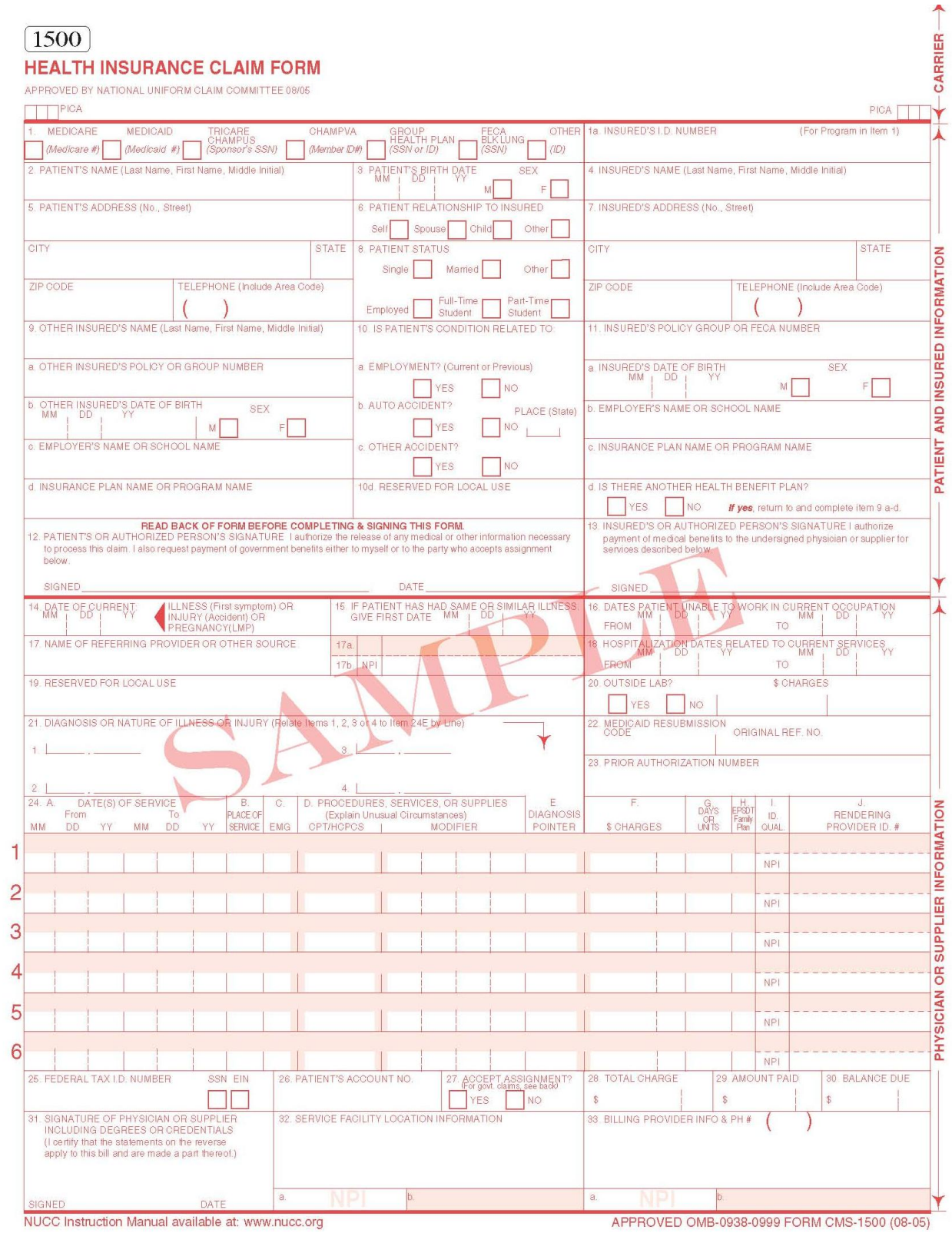
Billing Tip 

Be sure to include prior authorization number, timely filing TCN, proper procedure codes, modifiers, units, etc., to prevent your claim from denying inappropriately.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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'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

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 MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

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. 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											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

CMS-1500 Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
1	**Required**	**Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other:** For Primary Medicaid claims, enter an X in the box marked Medicaid. For Medicare crossover claims, enter X in both the Medicare and Medicaid boxes.
1a	**Required**	**Insured's ID Number:** Enter the patient's 9-digit Beneficiary ID Number (Enrollee ID) as shown on their Medicaid card.
2	**Required**	**Patient's Name:** Enter patient's full last name, first name and middle initial (Enrollee Name) as printed on their Medicaid card. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq.) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.
3	**Required**	**Patient's Birth Date, Sex:** Enter the patient's birth date in MM DD CCYY format. Enter an X in the correct box to indicate the sex of the patient.
4	Not Required	Insured's Name
5	**Required**	Patient's Address, City, State, Zip Code, Telephone
6	Not Required	Patient Relationship To Insured
7	Not Required	Insured's Address, City, State, Zip Code, Telephone
8	Not Required	Patient Status
9	**Required if Applicable**	**Other Insured's Name**
9a	**Required if Applicable**	**Other Insured's Policy Or Group Number:** If the patient has TPL, enter the policy number with their primary carrier.
9b	**Required if Applicable**	**Other Insured's Date Of Birth, Sex:** Enter the birth date of the patient in the MM/DD/CCYY format.
9c	**Required if Applicable**	**Employer's Name Or School Name**
9d	**Required if Applicable**	**Insurance Plan Name Or Program Name:** enter the name of the primary carrier.
10a–c	**Required if Applicable**	**Is Patient's Condition Related To:** If the patient's condition is a result of a work-related circumstance/occurrence, an automobile accident or other type of accident, check "YES" on the appropriate line.
10d	**Required if Applicable**	**Reserved for Local Use: If billing laboratory services, the CLIA number must be entered.**
11	**Required if Applicable**	**Insured's Policy Group or FECA Number:** If the beneficiary has two forms of TPL other than Medicaid, enter the policy number of the secondary carrier.
11a	**Required if Applicable**	**Insured's Date Of Birth, Sex:** Enter policy holder's birth date in the MM/DD/CCYY format and sex.
11b	**Required if Applicable**	**Employer's Name or School Name**
11c	**Required if Applicable**	**Insurance Plan Name or Program Name:** If the beneficiary has two forms of TPL other than Medicaid, enter the name of the beneficiary's secondary carrier.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
11d	**Required if Applicable**	**Is There Another Health Benefit Plan?**
12	**Required if Applicable**	**Patient's or Authorized Person's Signature:** Enter Signature on File or legal signature with the date in MM/DD/YY format.
13	Not Required	Insured's or Authorized Person's Signature
14	Not Required	Date Of Current: Illness, Injury, Pregnancy
15	Not Required	If Patient has had Same or Similar Illness
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	**Required if Applicable**	**Name of Referring Provider or Other Source: E**nter the name of the referring provider.
17a	**Optional**	**Other ID#:** Enter the eight-digit Mississippi Medicaid provider number of the referring provider.
17b	**Required if Applicable**	**NPI #:** Enter the NPI of the referring provider.
18	**Required if Applicable**	**Hospitalization Dates Related to Current Services:** Enter the admission/discharge dates in MM/DD/YY
19	Not Required	Reserved for Local Use
20	Not Required	Outside Lab Charges
21	**Required**	**Diagnosis or Nature of Illness or Injury:** Enter the beneficiary's ICD-9-CM Codes in priority order. Up to four diagnoses may be entered.
22	**Required if Applicable**	**Medicaid Resubmission:** Complete this field to show proof of timely filing on a resubmission of a claim twelve months past the original date of service. • In the "ORIGINAL REF. NO" area enter the first Transaction Control Number (TCN) assigned to the claim.
23	**Required if Applicable**	**Prior Authorization Number:** If you obtained authorization for an item on this claim, enter your Authorization Number in this field without hyphens, dashes, spaces, etc.  **Enter only one Authorization Number per claim form. Complete additional forms if needed.**
24A	**Required**	**Physician -Administered Drugs - NDC REQUIRED:** Enter the 11-digit NDC code in the top, shaded portion of the detail line of Locator 24 A. The corresponding HCPCS code should be entered in the bottom, un-shaded portion of Locator 24D. Other required information, including the number of units administered to the patient and the actual cost of the drug should be entered in the appropriate fields in Locator 24. **Date(s) of Service:** Enter the begin ("From") and end ("To") dates of service in the bottom, un-shaded portion of Locator 24A. Enter the date in the MM/DD/YY format. If a service was provided on one day only, enter the same date twice.
24B	**Required**	**Place of Service:** Enter the code indicating where the service was rendered. See **Figure 3-2** for place of service codes.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
24C	**Required if Applicable**	**EMG:** Enter "P" (Positive) or "N" (Negative) in the appropriate box to indicate the PHRM/ISS Medical Risk Screening Code T1023-TH (maternal) or T1023-EP (Infant).
24D	**Required** **Required if Applicable** **Required if Applicable**	**Procedures, Services, Or Supplies CPT/HCPCS Modifier:** • **Procedure Code** – Enter the appropriate CPT-4/HCPCS code that identifies the service provided. • **Procedure Modifier** – Enter the appropriate procedure modifier that further qualifies the service provided. • **Explain Unusual Circumstances**- Attach a written description of any unusual circumstances/services.
24E	**Required**	**Diagnosis Pointer:** Enter only one diagnosis indicator (1, 2, 3, or 4) that identifies appropriate diagnosis for the procedures. These indicators should correspond to the line numbers of the diagnosis codes listed in field 21.
24F	**Required**	**Charges:** Enter your usual and customary charge for each listed service. For injections, the actual cost of the drug should be entered in this field.
24G	**Required**	**Days Or Units:** Enter the number of days or the number of units being billed per procedure.
24H	**Required if Applicable**	**EPSDT/Family Plan:** Enter an "E" if the service is a result of a MS Cool Kids (EPSDT) screening. Enter an "F" if the service is related to Family Planning.
24I	Not Required	ID Qualifier
24J	**Required if Applicable**	**Rendering Provider ID #:** Enter the rendering provider's individual 10-digit National Provider Identifier (NPI) in the bottom, un-shaded half of the claim line.
25	Not Required	**Federal Tax ID Number:**
26	**Optional**	**Patient's Account No.** Enter your internal patient account number here. The patient account number will be printed on your Remittance Advice (RA) to further identify the beneficiary.
27	Not Required	Accept Assignment
28	**Required**	**Total Charge:** Enter the total of all the line item charges. Each claim form must be totaled in this field. Do not submit claims that are continued on the second page.
29	**Required if Applicable**	**Amount Paid:** Enter the total amount paid by all other insurance carriers (other than Medicare and Medicaid).  **Entering prior payments from Medicare and/or Medicaid in this field will result in a reduced or zero payment.**
30	Not Required	Balance Due:
31	**Required**	**Signature of Physician or Supplier:** The claim form must be signed and dated by the healthcare provider or authorized representative. Original rubber stamp and automated signatures are acceptable.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
32	**Required if Applicable**	**Service Facility Location Information:** Enter the name, address, city, state, and zip code of the location where services were rendered if other than patient's home or physician's office.
32a	Not Required	NPI#
32b	Not Required	Other ID#
33	**Required**	**Billing Provider Info & Phone #:** Enter the billing provider's name, address, zip code, and telephone number as shown on your Medicaid remittance advice and provider file.  **For individual providers, enter the name in the last name, first name format. For physician billing groups, enter the group's name as it appears on the Remittance Advice (RA) or the Medicaid file.**
33a	**Required**	**NPI #:** Enter the NPI number of the billing provider if the provider is considered a health-care services provider.
33b	**Optional**	**Other ID #:**  **EXCEPTION: Required For Atypical Providers - Enter the 8-digit Medicaid provider number.** ***The 8-digit MS Medicaid provider ID may be entered for health-care services providers.***

Figure 2.1 Checklist of Required Fields for CMS-1500 Claim Form

CMS-1500 Checklist for Required Fields		Required	Required, if Applicable	Optional	Not Required
1	Health Insurance Box	✓			
1a	Insured's I.D Number	✓			
2	Patient's Name	✓			
3	Patient's Birth Date and Sex	✓			
4	Insured's Name		✓		
5	Patient's Address	✓			
6	Patient's Relationship To Insured		✓		
7	Insured's Address		✓		
8	Patient Status				✓
9	Other Insured's Name		✓		
9a	Policyholder's number		✓		
9b	Policy holder's birth date and sex		✓		
9c	Employer's/school name		✓		
9d	Insurance plan name or program name		✓		
10 a-c	Is Patient's Condition Related To Employment, Auto/Other Accident		✓		
10d	Reserved For Local Use		✓		
11	Insured's Policy Group Or FECA Number		✓		
11a	Insured's Date Of Birth And Sex		✓		
11b	Employer's Name Or School Name		✓		
11c	Insured Plan Name Or Program Name		✓		
11d	Is There Another Health Benefit Plan?		✓		
12	Patient's Signature	✓			
13	Authorization				✓
14	Date Of Current				✓
15	If Patient Has Had Same Or Similar Illness				✓
16	Dates Patient Unable To Work In Current Occupation				✓
17	Name Of Referring Physician Or Other Source		✓		

CMS-1500 Checklist for Required Fields		Required	Required, if Applicable	Optional	Not Required
17a	I.D. Number Of Referring Physician			✓	
17b	Referring Provider NPI		✓		
18	Hospitalization Dates Related To Current Services		✓		
19	Reserved For Local Use				✓
20	Outside Lab Charges				✓
21	Diagnosis	✓			
22	Medicaid Resubmission Or Original Ref. No.		✓		
23	Prior Authorization No.		✓		
24a	Dates Of Service	✓			
24b	Place Of Service	✓			
24c	EMG				✓
24d	Procedure Code	✓			
	Explain Unusual Services/Circumstances		✓		
	Procedure Modifier		✓		
24e	Diagnosis Code	✓			
24f	Charges	✓			
24g	Days Or Units	✓			
24h	ESPDT Family Plan		✓		
24i	ID Qualifier				✓
24j	Rendering Provider ID #		✓		
25	Federal Tax I.D. No.				✓
26	Patient Account No.			✓	
27	Accept Assignment?				✓
28	Total Charges	✓			
29	Amount Paid		✓		
30	Balance Due				✓
31	Signature Of Physician Or Supplier	✓			
32	Service Facility Location		✓		
32a	Service Facility NPI				✓
32b	Service Facility Other ID#				✓
33	Billing Provider Info & Ph#	✓			
33a	Billing Provider NPI	✓			
33b	Billing Provider Other ID #			✓	

Figure 2-2. Place of Service Codes

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Freestanding Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service