



Section: CMS-1500 Claim Form Instructions

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, unshaded 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										PICA																								
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BLK/LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)														
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)														
CITY					STATE					6. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE														
ZIP CODE					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>														
d. INSURANCE PLAN NAME OR PROGRAM NAME										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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EP501 Family Plan I. ID QUAL J. RENDERING PROVIDER ID. #														
1										NPI										NPI														
2										NPI										NPI														
3										NPI										NPI														
4										NPI										NPI														
5										NPI										NPI														
6										NPI										NPI														
25. FEDERAL TAX I.D. NUMBER					SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					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

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 <u>secondary</u> 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: Enter 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	<p>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.</p> <ul style="list-style-type: none"> In the "ORIGINAL REF. NO" area enter the first Transaction Control Number (TCN) assigned to the claim.
23	Required if Applicable	<p>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.</p> <p> Enter only one Authorization Number per claim form. Complete additional forms if needed.</p>
24A	Required	<p>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.</p> <p>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.</p>
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: <ul style="list-style-type: none"> • 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	<p>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.</p> <p> 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.</p>
33a	Required	NPI #: Enter the NPI number of the billing provider if the provider is considered a health-care services provider.
33b	Optional	<p>Other ID #:</p> <p> EXCEPTION: Required For Atypical Providers - Enter the 8-digit Medicaid provider number.</p> <p><i>The 8-digit MS Medicaid provider ID may be entered for health-care services providers.</i></p>

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