CMS 1500 – Physicians and Non-Institutional Providers
Data Element Requirements for Non-electronic Clean Claims

For any conflicts between the following reference materials and the rules, the rules prevail.

Field #	Data Element	HB 610 required as indicated (unless otherwise agreed to by contract)	SB 418 Emergency Rules as indicated (Cannot be changed by contract)	SB 418 Final Rules as indicated (cannot be changed by contract)
1a	Subscriber's or patient's plan ID number	R	R	R
2	Patient's name	R	R	R
3	Patient's date of birth and gender	R	R	R
4	Subscriber's name	R	R	R - if shown on patient's ID card
5	Patient's address (street or P.O. Box, City, State, Zip)	R	R	R
6	Patient's relationship to subscriber	R	R	R
7	Subscriber's address	R	R – May enter "same" if address same as patient's shown in Field 5	R – May enter "same" if address same as patient's shown in Field 5
9	Other insured's or enrollee's name	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*
9a	Other insured's or enrollee's policy/group number	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*
9b	Other insured's or enrollee's date of birth	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*
9c	Other insured's or enrollee's plan name (employer, school, etc.)	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*, Facility based radiologist, pathologist, anesthesiologist can enter NA if information is unknown	R - if Field 11d is answered "yes"*, Facility based radiologist, pathologist, anesthesiologist can enter NA if information is unknown
9d	Other insured's or enrollee's HMO or insurer name	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*	R - if Field 11d is answered "yes"*
10	Whether patient's condition is related to employment,	R	R – but facility based radiologists, pathologists or	R – but facility based radiologists, pathologists or

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10 cont…	auto accident, or other accident		anesthesiologists shall enter “N” if answer is “No” or the information is unknown.	anesthesiologists shall enter “N” if answer is “No” or the information is unknown.
10d	Corrected Claim	Not required	R - if duplicate claim, enter “D”, or if corrected claim, enter “C”	R - if duplicate claim, enter “D”, or if corrected claim, enter “C”
11	Subscriber’s policy number	R	R	R
11a	Subscriber’s birth date and gender	R	Not required	Not required
11b	Subscriber’s plan name (employer, school, etc.	R - if health plan is a group plan	Not required	Not required
11c	HMO or preferred provider carrier name	R	R	R
11d	Disclosure of any other health benefit plans	R - If answer is “no” provider must have on file patient’s statement signed within last 12 months that there is no other coverage.*	R - If answer is “no” provider must have on file patient’s statement signed within last 12 months that there is no other coverage.*	R - If answer is “no” provider must have on file patient’s statement signed within last 12 months that there is no other coverage.*
12	Patient’s or authorized person’s signature or a notation that the signature is on file with the physician or provider	R	R	R
13	Subscriber’s or authorized person’s signature or notation that the signature is on file with the physician or provider	R	R	R
14	Date of current, illness, injury, or pregnancy	R	R - only if due to an accident	R - only if due to an accident
15	First date of previous, same or similar illness	R	Not required	Not required
17	Name of referring physician or other source	Not required	R - for primary care and specialty physicians and hospitals. If no referral, enter “self-referral or none.”	R - for primary care and specialty physicians and hospitals. If no referral, enter “self-referral or none.”

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17a	ID number of referring physician	Not required	R - for primary care and specialty physicians and hospitals. If no referral, enter “self-referral or “none”	R - for primary care and specialty physicians and hospitals. If no referral, enter “self-referral or “none”
19	Narrative description of procedure	Not required	R – if physician or provider uses an unlisted or not classified procedure code or NDC code for unlisted drugs.	R – if physician or provider uses an unlisted or not classified procedure code or NDC code for drugs.
21	Diagnosis codes or nature of illness or injury	R	R – up to 4 diagnosis codes may be entered but at least one is required (primary diagnosis must be entered first.)	R – up to 4 diagnosis codes may be entered but at least one is required (primary diagnosis must be entered first.)
23	Prior authorization number	R – when prior authorization is required	R - if services have been verified per §19.1724 of this title (Verification). Otherwise, a prior authorization number is required when prior authorization is required.	R - if services have been verified per §19.1724 of this title (Verification). Otherwise, a prior authorization number is required when prior authorization is required and granted
24A	Date(s) of Service	R	R	R
24B	Place of service codes	R	R	R
24C	Type of service code	R	Not required	Not required
24D	Procedure/Modifier code	R	R	R
24E	Diagnosis code by specific service	R	R – with first code linked to the applicable diagnosis code for that service in Field 21	R – with first code linked to the applicable diagnosis code for that service in Field 21
24F	Charge for each listed service	R	R	R
24G	Number of days or units	R	R	R
25	Physician’s or provider’s federal tax ID number	R	R	R
27	Whether assignment was accepted	R – when assignment under Medicare has been accepted	R – when assignment under Medicare has been accepted	R – when assignment under Medicare has been accepted

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28	Total Charge	R	R	R
29	Amount paid	R - if amount has been paid by or on behalf of the patient or subscriber or by a primary plan.	R - if amount has been paid by or on behalf of the patient or subscriber or by a primary plan.	R - if amount has been paid by or on behalf of the patient or subscriber or by a primary plan.
30	Balance due	R - if an amount has been paid by or on behalf of patient or subscriber	Not required	Not required
31	Signature of physician or provider or notation that signature is on file with the carrier	R	R	R
32	Name and address of facility where services were rendered (if other than home or office)	R	R	R
33	Physician or provider's billing name and address	R	R – in addition to telephone number. Provider number is required if carrier required provider numbers and gave notice of the requirement to physician/provider prior to 6-17-2003.	R – in addition to telephone number. Provider number is required if carrier required provider numbers and gave notice of the requirement to physician/provider prior to 6-17-2003.

***** If answer in field 11d is "Yes", then data elements in fields 9, 9a, 9b, 9c, and 9d must be completed. If answer is "No", then fields 9, 9a, 9b, 9c, and 9d are not essential data elements if the physician or provider has on file a statement signed by the patient/insured within the last 12 months that there is no other coverage. Such statement may be in the form of initial or annual office visit questionnaires, patient sign-in sheets, a routine record update, etc.