08/05 CMS 1500

Claim form billing instructions for the Department of Human Services

DHS
Oregon Department of Human Services

Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the 08/05 CMS 1500 billing form correctly the first time. If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~ DHS ~

MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).

- This system is a combination of people and computers working together to process claims.

- This system performs daily edits for presence and validity of data.

- DHS staff only reviews claims that MMIS cannot make a payment decision on based on the information submitted.

Claims Processing

- Paper claims submitted by mail go to DHS Office of Document Management (ODM) Imaging Unit.

- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.

- Make sure your claim form meets OCR specifications.

- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

Before you bill

- Read your provider guidelines.

- Verify client eligibility on the date of service.

- Make sure you bill all prior resources first. DHS is the payer of last resort.

- Use commercially available "red form" versions of the 08/05 CMS 1500.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink; never use red ink.

- Make sure your handwriting is legible.

- If possible, submit no more than six lines of services per claim form.

- Do not use liquid whiteout.

- Check your printer alignment.

Form suppliers

- The 08/05 CMS 1500 form is not supplied by DHS.

- Forms are available by contacting one of the following:

  - Local business forms suppliers
  - Oregon Medical Association (503-226-1555)
  - U.S. Government Printing Office (202-512-1800)

Services billed on the CMS 1500

- Durable Medical Equipment Services

- School Based Medical Services

- Professional Services
  - Contract RN
  - Licensed professionals

- Non-Medical Professional
  - Secured Transportation
  - Copy Services
  - Miscellaneous Medical Services
  - Sex Offender Polygrapher
  - Wheelchair Coach/Services
  - Taxi

Services billed on the CMS 1500

- Medical Professional Providers
  - Air/Ground Ambulance
  - Ambulatory Surgical Center
  - Billing Provider
  - Billing Service/Agent
  - Chemical Dependency
  - Chiropractor
  - Family Planning Clinic
  - Free Standing Birthing Center

- Hearing Aid Provider
- Independent Lab
- Licensed Midwife
- Naturopath
- Mental Health
- Nurse Anesthetist
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physical Therapist
- Physician

Services billed on the CMS 1500

- Medical Professional Providers continued…
  - Podiatrist
  - Portable X-Ray
  - Psychologist
  - Public Clinic
  - Registered Nurse
  - Rural Health Center
  - Federally Qualified Health Center
  - Dispensing Optician
  - Indian Health
  - Lifeline
  - Targeted Case Management

Services billed on the CMS 1500

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:

  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Introducing the CMS 1500 08-05 version

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | PICA | | | | | | | | 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 ☐

CITY   STATE

ZIP CODE   TELEPHONE (Include Area Code) (   )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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 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? 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.

08-05 version

- Not sure if you are using the correct form?

The bottom right corner should say 08-05.

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

Top section

Red = Required   Yellow = Optional

Box 1a - Required

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

X X # # # X # X

Recipient ID Number

- Enter the client's eight-character prime identification number.

- Enter the number exactly as it appears on the Medical Care Identification.

Box 2 - Required

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

Patient, Your

Patient's Name

- Enter the client's name exactly as it is printed on the Medical Care Identification.

- Use the client's last name first.

- Do not use nicknames.

Box 9 - Optional

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

NC

Third Party Resource

- If the client has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.

- A code must be listed when the other insurance did not make a payment.

- A code is always required when the client has more than one other insurance carrier.

- TPR codes can be found in your specific provider supplemental information, or on the following slides.

Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility

Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient

Multiple carrier TPR codes continued on next two slides

Multiple carrier TPR codes

SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder

Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

Box 10 - Optional

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

☐ YES   ☐ NO

b. AUTO ACCIDENT?

PLACE (State)

☐ YES   ☐ NO   ☐___

c. OTHER ACCIDENT?

☐ YES   ☐ NO

Patient's Condition

- Check the appropriate box only when an injury is involved.

- Do not check any boxes if there is no injury to report.

Middle section

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 MM DD YY 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 MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? $ CHARGES ☐ YES ☐ NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. |____ . _____ 2. |	3. |____ . ____ 4. |	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

Red = Required   Yellow = Optional

Box 17a - Optional

17a.		# # # # # #

Referring Provider Number

- Enter the six-digit (DHS issued) provider number of the referring provider.

- This may be required if the client has a Primary Care Manager (PCM) or the service requires a referral (*e.g.,* Physical Therapy, Occupational Therapy or Speech Therapy).

Box 17b - Optional

17b.	NPI	##########

Referral National Provider Identifier (NPI)

- If information was entered in box 17a (Primary Care Manager, or other referral) the corresponding NPI is entered here.

- Enter the ten-digit NPI of the referring provider.

Box 21 - Required

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	
1. **786 59**	3. **250 61**
2. **414 01**	4. **465 9**

Diagnosis Code

- Enter the client's diagnosis/condition.

- The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.

- You may enter up to four codes and they must be carried out to its highest degree of specificity.

- Do not use the decimal point.

Note: Diagnosis codes are not required for transportation providers.

Box 23 - Optional

23. PRIOR AUTHORIZATION NUMBER

# # # # # # # # #

Prior Authorization Number

- If the service you provided requires prior authorization (PA), enter the nine-digit prior authorization number that was issued for the service.

- Only use one prior authorization number per claim form.

- Do not bill prior authorized and non-authorized services on the same claim form.

Bottom section

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER						
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	
														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.

Red = Required   Yellow = Optional

Box 24A - Required

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
04	01	07			
04	03	07			
04	05	07	04	06	07

Date of Service

- This box must list numeric dates of service.

- If billing for one day, complete only the "from" column.

- If the "from and to" dates are used, a service must be on consecutive days and provided no more than once per day.

Box 24B - Required

B. PLACE OF SERVICE
11
11
11

Place of Service

- Enter the two-digit place of service code of where the service was provided.

- Place of service codes can be found in CPT/HCPCS codebooks or on the CMS Web site at:

  www.cms.hhs.gov/placeofservicecodes/downloads/posdatabase.pdf

- One-digit place of service codes are also acceptable.

  (Refer to the following slide for DMAP place of service codes).

Place of service codes

1	Inpatient Hospital
2	Outpatient Hospital
3	Practitioner Office
4	Patient Home
5	Day Care Facility
6	Night Care Facility
7	Intermediate Care Facility
8	Skilled Nursing Facility
A	Independent Lab
B	Other Medical/Surgical Facilities/School District Facility
C	Residential Treatment Center
D	Specialized Treatment Center

Box 24C - Optional

C.
EMG
Y
N

Emergency Indicator

- If the service you provided was a result of an emergency, enter a "Y" for "yes" in this box for each line item.

- If this was not an emergent service, leave blank or enter a "N" for "non-emergent".

Box 24D - Required

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
CPT/HCPCS	MODIFIER			
99213	21			
99213	21			
99213	21			

Procedure Code

- Enter the five-digit/character CPT or HCPCS code(s) for the specific service provided.

- Optional - Enter up to four two-digit national modifiers that relate to this service.

- For procedure codes that indicate "unlisted," you must attach an operative/medical report.

Box 24E - Required

E. DIAGNOSIS POINTER
1
1
1

Diagnosis Pointer

- Enter the one-digit diagnosis code reference number (pointer) as shown in box 21 to relate the date of service and the procedure performed to the primary diagnosis.

- Do not enter the actual ICD-9-CM code here.

Box 24F - Required

F.
$ CHARGES
93 | **00**
93 | **00**
186 | **00**
|
|
|

Total Charges

- Enter the total usual and customary charge for each line.

- Do not list credits.

- Do not use dashes.

- DHS will not calculate your charge if billing for more than 1 item (unit).

Box 24G - Required

G. DAYS OR UNITS
1
1
2

Service Days or Units

- Enter the number of days or units for each number of consecutive days or services as indicated in box 24A.

- Some services are billed by units depending on the service provided.

Box 24J - Optional

Rendering Provider ID

- This box is only required when clinics or group practices use a specific billing provider number in box 33. This identifies who rendered the service.

- Shaded - Enter the six-digit (DHS issued) provider number of the individual rendering the service.

- Non-shaded - Enter the ten-digit NPI of the rendering provider that was identified in the shaded area.

Note: This box is not required for transportation providers.

Box 26 - Optional

26. PATIENT'S ACCOUNT NO.

X123400

Patient Account Number

- Enter your patient account number here.

- This box allows up to twelve characters.

- This number will appear on your Remittance Advice (RA).

Box 28 - Required

28. TOTAL CHARGE

$ **372 00**

Total Charge

- Enter the total charge amount for all services listed in column 24F.

- Each claim form is a separate document, and is to be totaled as such.

Box 29 - Optional

29. AMOUNT PAID

$

Amount Paid

- Enter the total amount paid by any prior resource(s).

- Do not include write-offs.

- Do not include how much DHS previously paid.

- Do not include copayments.

Box 30 - Required

30. BALANCE DUE

$ **372** **00**

Balance Due

- Enter the balance due.

- Box 28 minus box 29 must equal box 30.

Box 33 - Required

33. BILLING PROVIDER INFO & PH #	( )
Billing Provider **PO Box ###** **Anytown, OR 97###**	
a. **##########**	b. **######**

Billing Provider Information

- Box 33 - (Billing provider info & phone number) Enter the name and address of the provider that is requesting to be paid for the services rendered.

- 33a - (NPI) Enter the ten-digit NPI of the billing provider.

- 33b - (Other ID) Enter the six-digit (DHS issued) provider number of the billing provider.

  Note: Non-medical services do not require NPI (*e.g.,* taxis).

COMPLETED

EXAMPLE

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | PICA | | | | | | PICA | | |

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLKLUNG (SSN) OTHER (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient, Name

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)
NC

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? PLACE (State) YES ☐ NO ☐

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 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? YES ☐ NO ☐ **$ CHARGES**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. **786 59**   3. **250 61**
2. **414 01**   4. **465 9**

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 04 01 07	11		99213 21	1	93 00	1		NPI	##### #########
2 04 03 07	11		99213 21	1	93 00	1		NPI	##### #########
3 04 05 07 04 06 07	11		99213 21	1	186 00	2		NPI	#####
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.
X123400

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

28. TOTAL CHARGE $ **372 00**

29. AMOUNT PAID $

30. BALANCE DUE $ **372**

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 # ( )
00
Billing Provider
PO Box ###
Anytown, OR 97###

a. **#########**   b. **#####**

NUCC Instruction Manual available at: www.nucc.org

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

Supplemental information

Box 24A - 24H

- DMAP accepts the following types of supplemental information that can be entered in the shaded line across box 24A through box 24H:

  - Anesthesia duration in hours and/or minutes with start and end times
  - Narrative description of unspecified codes
  - National Drug Codes for drugs
  - Vendor Product Number
  - Health Care Uniform Code, formerly Universal Product Code
  - Contract rate

Supplemental qualifiers

- The following qualifiers are to be used when reporting these services:

Qualifier	Description
7	Anesthesia
ZZ	Narrative description of unspecified codes
VP	Vendor Product Number
OZ	Health Care Uniform Code
CTR	Contract rate
N4	National Drug Code, also use the following:
F2	▪ International unit
GR	▪ Gram
ML	▪ Milliliter
UN	▪ Unit

Supplemental items

- More than one supplemental item can be reported.

- Enter the first qualifier and number/code/information.

- After the first item, enter three blank spaces and then the next qualifier and number/code/information.

- The following three slides are examples of different types of supplemental information.

Anesthesia services

Billed based on 15-minute units

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. #
7 Begin 1245 End 1415 Time 90 Minutes											**######**
05 01 07		**11**		**00770**	**P2**	**1**	**### ##**	**6**		NPI	**##########**

Billed based on minutes as units

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. #
7 Begin 1245 End 1415											**######**
05 01 07		**11**		**00770**	**P2**	**1**	**### ##**	**90**		NPI	**##########**

Unspecified / NDC services

Unspecified Code

24. A. DATE(S) OF SERVICE From / To						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. #
MM	DD	YY	MM	DD	YY														
ZZ Kaye Walker																			**######**
05	**01**	**07**				**12**		**E1399**					**1**	**###**	**##**	**1**		NPI	**##########**

National Drug Code

24. A. DATE(S) OF SERVICE From / To						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. #
MM	DD	YY	MM	DD	YY														
N400026064871 Immune Globulin Intravenous UN2																			**######**
05	**01**	**07**				**11**		**J1563**					**1**	**###**	**##**	**20**		NPI	**##########**

Vendor / Uniform services

Vendor Product Number

24. A. DATE(S) OF SERVICE From / To MM DD YY 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. #
VPA122BIC5D6E7G									**######**
05 **01** **07**	**11**		**A6410**	**1**	**### ##**	**1**		NPI	**##########**

Health Care Uniform Code

24. A. DATE(S) OF SERVICE From / To MM DD YY 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. #
OZ00301134678906									**######**
05 **01** **07**	**11**		**A6410**	**1**	**### ##**	**1**		NPI	**##########**

Resources

Where to mail your claim

- Mail your 08/05 CMS 1500 claim form to:

  DMAP

  PO Box 14955

  Salem, OR 97309-4957

Who to call if you need help

- Contact DMAP Provider Services if you need assistance or if you have questions concerning your CMS 1500 claim form.

- They can be reached at:

  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Thank you!