

# CMS 1500 Tip Sheet

## CMS-1500 Claim Form Tips

Outlined below are detailed instructions from CMS for completing the CMS-1500 claim form. The complete set of instructions are contained in the Medicare Claims Processing Manual. We recommend that you make a copy of the full text of these instructions. The full set of these instructions can be downloaded from the CMS website, which can be accessed by typing the following link into your internet browser:

<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

## Item 12 – Patient’s or Authorized Person’s Signature

The patient or authorized representative must sign and enter either a 6-digit date (MMDDYY), 8-digit date (MMDDCCYY), or an alphanumeric date UNLESS the signature is on file (emphasis added).

## Item 21 – Diagnosis Code

Enter the patient’s diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition, history of condition, etc).

## Item 24A – Date(s) of Service

Enter either a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column G.

## Item 24D – Procedure, Service, or Supply

Enter the procedures, services, or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

*The HCPCS code J1740 (Boniva, ibandronate sodium, 1 mg) is appropriate to use in the physician office and hospital outpatient setting. Please note that Boniva Injection 3 mg/3 mL equals 3 units of J1740.*

## Item 24E – Diagnosis Code

Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service: either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses in item 21. However, since some payors may accept multiple codes, please refer to your payor for local rules.

## Item 24F – Charges

Enter the charge for each listed service.

## Item 24G – “Days/Units”

Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral “1” must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form. When multiple services are provided, enter the actual number provided.

*The HCPCS code J1740 (Boniva, ibandronate sodium, 1 mg) is appropriate to use in the physician office and hospital outpatient setting. Please note that Boniva Injection 3 mg/3 mL equals 3 units of J1740.*

## Item 27 – “Accept Assignment”

A provider that accepts assignment agrees to take Medicare’s allowed amount (amount Medicare pays and patient’s co-insurance) for a covered service as payment in full. Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.

If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

# Sample Form CMS 1500

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA															
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										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		4. INSURED'S NAME (Last Name, First Name, Middle Initial)													
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)													
CITY					STATE					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)		a. INSURED'S DATE OF BIRTH													
b. OTHER INSURED'S DATE OF BIRTH										b. AUTO ACCIDENT?		b. EMPLOYER'S NAME OR SCHOOL NAME													
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT?		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?													
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.										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 _____ DATE _____										SIGNED _____															
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
require 19. RESERVED FOR LOCAL USE										17b. NPI		FROM _____ TO _____													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										20. OUTSIDE LAB?		22. MEDICAID RESUBMISSION CODE													
1. _____										<input type="checkbox"/> YES <input type="checkbox"/> NO		23. PRIOR AUTHORIZATION NUMBER													
2. _____												Item 24 G. Indicate number of 1mg units administered. (3mg/3mL of Boniva injection = 3 units)													
3. _____																									
4. _____																									
24. A. DATE(S) OF SERVICE From _____ To _____										B. PLACE OF SERVICE		C. PROCEDURE(S) CPT/HCPCS		D. DIAGNOSIS		E. CHARGES		F. DAYS OR UNITS		G. EPST Family Plan		H. ID. QUAL		I. RENDERING PROVIDER ID. #	
1. _____										J1740		_____		_____		_____		_____		NPI					
2. _____										_____		_____		_____		_____		_____		NPI					
3. _____										_____		_____		_____		_____		_____		NPI					
4. _____										_____		_____		_____		_____		_____		NPI					
5. _____										_____		_____		_____		_____		_____		NPI					
6. _____										_____		_____		_____		_____		_____		NPI					
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.		27. BALANCE DUE		28. AMOUNT PAID		29. 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.)										32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #													
SIGNED _____ DATE _____										a. NPI		b. NPI													

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Item 21. Indicate diagnosis using appropriate ICD-9-CM Code(s)

Item 24E. Refer to diagnosis for service listed (see Box 21)

Item 24D. Indicate appropriate CPT and HCPCS code and modifiers if required.