Appendix I: Completing the CMS-1500 claim form

The CMS-1500 Claim Form is a universal claim form and is the "approved" form that must be used when billing for professional services. Approved forms will say "Approved OMB-0938-1197 FORM 1500 (02-12)" on the bottom right hand corner. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing the Agency. Some field titles may not reflect their usage for a particular claim type. This form is not available through Washington Health Care Authority but should be available through your local office supplier.

Field	Name	Action
1a	ProviderOne Client ID	Enter the ProviderOne Client ID.
2	Patient's Name	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. If billing for a baby on mom's ID, enter the baby's name here. If the baby is un-named, use the mom's last name and "baby" as the first name. **Note:** Be sure to insert commas separating sections of the name!
3	Patient's Birthdate Patient's Sex	Enter the client's birthdate in the following format: MMDDCCYY. Do not include hyphens, dashes, etc. Enter the patient's sex (gender). If billing baby on mom's ID, enter the baby's birth date instead. If billing baby on mom's ID, enter the baby's sex here.
4	Insured's Name	When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA), enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word "Same" may be entered.
5	Patient's Address	Enter the address of the client who received the services (the person whose name is in Field 2).
6	Patient Relationship to Insured	Check the appropriate box.
7	Insured's Address	Enter the address of the insured.
9	Other Insured's Name	If there is other (primary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a	Other Insured's Policy or Group Number	Enter the other insured's policy or group number.
9b	Other Insured's Date of Birth and Gender	Check the appropriate box for the insured's gender and enter the birthdate in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.

Field	Name	Action
9d	Insurance Plan Name or Program Name	Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). Please note: Apple Health, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are inappropriate entries for this field.
10	Patient's Condition Related To	Check yes or no to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field 24. Indicate the name of the coverage source in field 10d (L&I, name of insurance company, etc.).
11	Insured's Policy Group or FECA (Federal Employees Compensation Act) Number	Primary insurance, when applicable. This information applies to the insured person listed in Field 4. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate the client has other insurance coverage and Medicaid is the payer of last resort.
11a	Insured's Date of Birth and Gender	Check the appropriate box when applicable for the insured's gender and enter the birthdate if different from field 3 in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
11c	Insurance Plan Name or Program Name	When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: This may or may not be associated with a group plan.)
11d	Is there another Health Benefit Plan?	Required if the client has other insurance. Indicate yes or no. If yes, you should have completed Fields 9a.-d. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check yes. If 11d is left blank, the claim may be processed and denied in error.
14	Date of Current Illness, Injury, or Pregnancy	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
15	If Patient Has Had Same or Similar Illness	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
16	Dates Patient Unable to Work in Current Occupation	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
17	Name of Referring Physician or Other Source	When applicable, enter the referring physician or Primary Care Case Manager (PCCM) servicing provider's name
17b	ID Number of Ordering/Referring Physician	When applicable, enter the NPI number of the ordering/referring physician. The provider reported here must be enrolled as a Washington State Medicaid provider. When billing for services provided to PCCM clients: Enter the National Provider Identifier (NPI) of the PCCM's servicing provider who referred the client for the service(s).
18	Hospitalization Dates Related to Current Services	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.

Field	Name	Action
19	Reserved for Local Use	This field is used for comments that require an Apple Health claims specialist to review a claim before payment is made. To make any of the following comments, put "SCI=" and the corresponding letter on the list below: • **B** – BABY ON MOMS CLIENT ID Use Twin A, Twin B; Triplet A, Triplet B, Triplet C when applicable • **F** – ENTERAL NUTRITION – CLIENT NOT ELIGIBLE FOR WIC • **H** – CHILDREN WITH SPECIAL HEALTHCARE NEEDS • **I** –INVOLUNTARY TREATMENT ACT (ITA)(Legal Status) • **K** – NOT RELATED TO TERMINAL ILLNESS (Hospice Client) • **V** – VOLUNTARY TREATMENT (Legal Status) • **Y**– SPENDDOWN AMOUNT (and list the amount) This is also the location to put NDCs, if applicable. Indicate what line the NDC is for by putting "LN#" before the NDC. **Note:** Baby on Mom's Client ID can only be used during the first 60 days of baby's life.
20	Outside Lab?	If applicable, check the appropriate box and enter charges.
21	Diagnosis or Nature of Illness or Injury	Enter the appropriate diagnosis code(s) in areas A-L, with A being primary.
22	Medicaid Resubmission	When applicable. If this billing is being submitted beyond the initial timely filing deadline, enter the TCN that verifies that the claim was originally submitted within the time limit. (The TCN number is the claim number listed on the Remittance and Status Report.) Also put TCN numbers in this field for adjusting or voiding claims. They must be in the following format: • 7-300629600000340000 (replace/adjustment) • 8-300629600000340000 (void/cancel)
23	Prior Authorization Number	When applicable. If the service or hardware being billed requires prior authorization, enter the assigned number.
24a	Date(s) of Service	Enter the "from" and "to" dates of service.

Field	Name	Action
24b	Place of Service	Enter the appropriate two digit code. For example: 11- Office 31- Skilled Nursing Facility 32- Nursing Facility The Agency requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Claims with inaccurate place of service designations will be denied.
24d	Procedures, Services or Supplies CPT/HCPCS	Enter the appropriate procedure code for the service(s) being billed. When appropriate enter a modifier(s).
24e	Diagnosis Pointer	Enter the diagnosis pointer by entering A-L to correspond to field 21. The first diagnosis should be the principal diagnosis. Follow additional digit requirements per ICD-10. Do not enter the actual diagnosis code in this field. Please do not enter a comma or any other punctuation in this field.
24f	Charges	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with the remittance amount.
24g	Days or Units	Enter the total number of days or units for each line. These figures must be whole units.
24i	ID Qualifier	Enter the taxonomy qualifier ZZ if required by Medicare or any other primary carrier. ProviderOne ignores this field but some carriers require it in order for field 24j to be forwarded to HCA.
24j	Rendering Provider ID# If applicable~ Reference (Outside) Laboratory	Enter the taxonomy code in the top half of the field for the rendering provider, if applicable. Enter the NPI for the rendering provider in the bottom half of the field. This information is only needed if it is different than fields 33a and 33b. For more information on taxonomy codes, please see Appendix L. The rendering provider must be enrolled as a Washington State Medicaid provider prior to start of treatment. Enter the NPI number of the reference (outside) laboratory here.

Field	Name	Action
25	Federal Tax ID Number	Enter in the Federal Tax ID or Social Security number and indicate via the check boxes which number is being used.
26	Patient's Account Number	Not required (optional field for your internal purposes). Enter alpha and/or numeric characters only. For example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report (RA) under the heading Patient Account Number.
27	Accept Assignment?	Check the appropriate box.
28	Total Charge	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29	Amount Paid	If there is insurance payment, show the amount here and attach a copy of the insurance EOB. If payment is received from a source other than insurance, specify the source in Field 10d. Do not use dollar signs or decimals in this field or put prior Medicare, Medicare Advantage, or Medicaid payments here.
30	Rsvd for NUCC Use	Enter total charges minus any amount(s) in Field 29. Do not use dollar signs or decimals in this field.
32	Service Facility Location Information	Enter the location address if different from Field 33 • Enter the location NPI • Enter the location Taxonomy. For more information on taxonomy codes, please see Appendix L. This field is required for Sleep Centers, Birthing Facilities, and Centers of Excellence when the location of service is different from the billing NPI's location.
Field	**Name**	**Action**
33	Physician's, Supplier's Billing Name, Address, Zip Code And Phone #	Enter the provider's Name and Address on all claim forms. • Enter the Billing Provider NPI • Enter the Billing Provider Taxonomy. For more information on taxonomy codes, please see Appendix L.