

Revised 1500 Claim Form Instructions

The National Uniform Claim Committee (NUCC) released a revised 1500 Claim Form, which is commonly referred to as the CMS-1500. The revised CMS-1500 (02/12) replaced the former CMS-1500 (08/05). Use of the revised form was required as of April 1, 2014. A sample form is attached for your review.

Important Revisions to the 1500 Claim Form

The revised 1500 Claim Form expands the length of some existing fields, incorporates several new fields, and accommodates use of your taxonomy. Some important fields that have been revised or added are listed below:

Field	Formerly Used For	What Changed?
17	Add the 2-Digit Qualifier in Box 17 for the referring (DN), ordering (DK) or supervising (DQ) provider. (Required for these provider types only)	No Change
17a Shaded	Insert non-NPI ID qualifier for state license number (OB), provider UPIN (1G), provider commercial (G2) or location number for supervising provider only (LU) (Optional)	No Change
17b	Enter the individual NPI number of the referring, ordering or supervising provider (Required for these provider types)	No Change
21 A-L	Diagnosis Codes 1-4	Lengthened Boxes for longer diagnosis codes and more boxes for more specific coding (For ICD-10).
24I	Formerly N5 or G2	Now populate the ZZ qualifier for taxonomy code submission.
24J Shaded	The Rendering Provider's Primary Taxonomy Code or your Passport Health Plan Legacy Provider ID Number	The Rendering Provider's Primary Taxonomy Code
24J Un-shaded	The Rendering Individual Provider's NPI Number	No Change
32	Insert standard USPS address (physical location)	No Change
32a	Insert Service Facility NPI	No Change
32b	Not Required	No Change
33A	The Billing Group Provider's NPI Number	No Change
33B	The ZZ Qualifier and Billing Provider's Primary Taxonomy Code or N5 with your Passport Health Plan Legacy Provider ID Number	The ZZ qualifier with the Billing Provider's Primary Taxonomy Code

For additional information about the 1500 Claim Form, please visit the NUCC's website at www.nucc.org. The NUCC offers a helpful Instruction Manual titled 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version, which features walkthroughs of each field of the 1500 Claim Form. You can currently access the guide in PDF form at the following location: http://www.nucc.org/images/stories/PDF/claim_form_manual_v1-3_7-06.pdf

We would also like to remind you of the requirements for electronic transactions. As a reminder, Passport Health Plan strongly recommends the continued use of plan identification numbers in addition to NPI.





REVISED

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA <input type="checkbox"/> PICA													
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) ABC1234567800								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John B.					3. PATIENT'S BIRTH DATE 03 20 71		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name) Doe, John B.				
5. PATIENT'S ADDRESS (No., Street) 1234 Main Street					6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					7. INSURED'S ADDRESS (No., Street) 1234 Main Street			
CITY Anytown			STATE NJ		8. RESERVED FOR NUCC USE			CITY Anytown			STATE NJ		
ZIP CODE 08999		TELEPHONE (Include Area Code) (856) 555-2222			ZIP CODE 08999		TELEPHONE (Include Area Code) (856) 555-2222						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Mary					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER 15974			
a. OTHER INSURED'S POLICY OR GROUP NUMBER 72431					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH 03 20 71		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME AmeriHealth PPO			
d. INSURANCE PLAN NAME OR PROGRAM NAME HMO, Inc.					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
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 this claim myself or to the party whose name is designated below.					SIGNED _____ DATE _____					SIGNED _____			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 10 28 06					15. OTHER DATE QUAL. _____ 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 Josephine Smith, M.D.					17a. 62 0123456789 17b. NPI 999999999					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 11 01 06 TO 11 04 06			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207LP2900X					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. 401 B. 251.8 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____					23. PRIOR AUTHORIZATION NUMBER 123456789					Individual Rendering Provider ID			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, S (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					24. A. 11 02 06 11 02 06 21 6 99205 A \$50 00 1 ZZ Ind. taxonomy Ind. NPI 2. 11 03 06 11 03 06 21 6 20600 25 B \$250 00 1 ZZ Ind. taxonomy Ind. NPI 3. _____ Modifier (if applicable) _____ NPI 4. _____ NPI 5. _____ NPI 6. _____ NPI					Referral/Preauthorization Number			
25. FEDERAL TAX I.D. NUMBER 22-1234567					26. SERVICE FACILITY LOCATION INFORMATION ABC Hospital 123 Street Anytown, NJ 08999					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 100 00 29. AMOUNT PAID \$ 0 00 30. Rsvd for NUCC Use	
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.) Richard B. Smith, M.D.					32. BILLING PROVIDER INFO & PH # ABC Medical Group 8 North American Street Anytown, NJ 08999					Billing taxonomy with ZZ			
SIGNED _____ DATE 1/5/15					a. 0000001234 b. 621234567002					a. 2222222222 b. ZZ1233X10000			

Required: Insert 2-digit Qualifier

Optional: Referring Provider's two-character qualifier ID

Optional: Referring Provider's Current Provider ID

Required: Referring Provider's NPI

ZZ qualifier ID and Billing Provider's Primary Taxonomy Code

Individual Rendering Provider ID

Provider's Federal Tax ID # (Billing Entity)

Physical Address Only No P.O. Box

Required: Service Facility NPI

Group Billing Provider NPI

Billing taxonomy with ZZ

837 P Data Field Requirements

837 P BILLING TAXONOMY LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2000A	Billing/Pay-To Provider Specialty Information	PRV	01	BI

Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2000A	Billing/Pay-To Provider Specialty Information	PRV	02	PXC

Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2000A	Billing/Pay-To Provider Specialty Information	PRV	03	Taxonomy Code

837 P BILLING PROVIDER LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2010AA	Billing Provider	NM1	08	XX

Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2010AA	Billing Provider Secondary Identification	REF	01	SY
				EI

837 P RENDERING PROVIDER LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2310B	Rendering Provider	NM1	08	XX

837 P RENDERING TAXONOMY LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2310B	Rendering Provider Specialty Information	PRV	01	PE

837 P RENDERING TAXONOMY LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2310B	Rendering Provider Specialty Information	PRV	02	PXC

837 P RENDERING TAXONOMY LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2310B	Rendering Provider Specialty Information	PRV	02	Taxonomy Code

837 P SERVICE FACILITY LOOP				
Loop ID	Loop Name	Segment Name	PRV Qualifier	PRV Value
2310C	Service Facility Location	NM1	01	77

Please let us know if you have any questions regarding these instructions. In addition, if you have any questions regarding the NPI, the application process, or reporting your NPIs to us, please contact your Provider Relations representative.