Tips for Completing the CMS-1500 Claim Form

This guide is designed to assist with the completion of the CMS-1500 claim form.

To help ensure that claims are submitted accurately to allow for timely payment, please review this document and access the National Uniform Claim Committee’s (NUCC) 1500 Health Insurance Claim Form Reference Instruction Manual, which is available at www.nucc.org.

Claim Forms

- Submit only the red drop out approved CMS-1500 (02-12) claim form.

Submitting Claims

Submit all paper claims to:

Excellus BlueCross BlueShield
P.O. Box 21146
Eagan, MN 55121

Form Completion

Details on how to complete the form are outlined on the following pages.

Follow these tips to help ensure proper scanning and timely processing:

- Enter the data within the boundaries of the fields provided and ensure all information is aligned properly. Do not write between lines.
- Type (in Arial or Times New Roman font) or print all information. Entries should be dark enough to be legible.
- Use black ink only. Red and blue ink cannot be properly "read" by the scanning equipment.
- Do not highlight the claim form or attachments. Highlighted information can become "blacked-out" when scanned.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, complete a new form.
- Capitalize alpha characters. Do not use special characters (e.g., dollar signs, decimals, dashes). Do not use commas to separate thousands.
- Do not write or use staples on the bar-code area.
- Do not use adhesive labels (e.g., address) or place stickers on the form. Do not use a rubber stamp in any fields on the form.

If you have questions or need assistance, please contact your Provider Relations representative.
HEALTH INSURANCE CLAIM FORM

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA  BIX (LUNG)  OTHER
   [Medicare#]  [Medical]  [Medicaid#]  [ID#]  [Member ID#]  [Health Plan#]  [ID#]  [ID#]

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

3. PATIENT'S BIRTH DATE
   MM  DD YY
   [R] [R] [R]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
   [R] [R] [R]

5. PATIENT'S ADDRESS (No., Street)
   [R] [R] [R]

6. PATIENT RELATIONSHIP TO INSURED
   [Self] [Spouse] [Child] [Other]
   [R] [R] [R] [R]

7. INSURED'S ADDRESS (No., Street)
   [R] [R] [R]

8. RESERVATION FOR NUCC USE
   [NR] [NR] [NR]

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

10. OTHER INSURED'S POLICY OR FECA NUMBER
    [S] [S] [S]

11. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
       [Y] [S] [N] [NO]
       [R] [R] [R] [R]
    b. AUTO ACCIDENT? (Specify)
       [Y] [S] [N] [NO]
       [R] [R] [R] [R]
    c. OTHER CONDITION?
       [Y] [S] [N] [NO]
       [R] [R] [R] [R]

12. PLACE OF SERVING PROVIDER
    [PLACE] [PLACE] [PLACE]
    [NR] [NR] [NR]

13. IS THERE ANOTHER HEALTH PLAN?
    [R] [R] [R]

14. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

15. Date
    [SIGN]

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM MM  DD  YY TO MM  DD  YY
    [R] [R] [R]

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    [NAME] [NAME] [NAME]
    [NR] [NR] [NR]

18. HOSPITALIZATION DAYS RELATED TO CURRENT SERVICES
    FROM MM  DD  YY TO MM  DD  YY
    [R] [R] [R]

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
    [R] [R] [R]

20. OUTSIDE LAB
    [R] [R] [R]

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    [ICD] [ICD] [ICD]
    [R] [R] [R]

22. REFERRAL
    [R] [R] [R]

23. PRIOR AUTHORIZATION NUMBER
    [NR] [NR] [NR]

24. DATE(S) OF SERVICE
    [MM  DD  YY] [MM  DD  YY]
    [R] [R] [R]

25. FEDERAL TAX ID # NUMBER
    [R] [R] [R]

26. INSURED'S ACCOUNT NUMBER
    [R] [R] [R]

27. ACCEPT ORIENTATION
    [R] [R] [R]

28. TOTAL CHARGE
    [NR] [NR] [NR]

29. AMOUNT PAID
    [NR] [NR] [NR]

30. BILLING PROVIDER INFO & PH #
    [NR] [NR] [NR]

Note: Field required for ancillary claims.

Key:
- R: Required in filing a claim
- NR: Not required, not used
- S: Situational, only use if specific to claim

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)
### TYPE OF HEALTH INSURANCE COVERAGE

**Select "Other"**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>INSURED ID NUMBER</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT'S NAME</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT'S BIRTH DATE/SEX</td>
</tr>
<tr>
<td>4</td>
<td>INSURED'S NAME</td>
</tr>
<tr>
<td>5</td>
<td>PATIENT'S ADDRESS/TELEPHONE NUMBER</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT'S RELATIONSHIP TO THE INSURED</td>
</tr>
<tr>
<td>7</td>
<td>INSURED'S ADDRESS/TELEPHONE NUMBER</td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCX USE</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED'S NAME</td>
</tr>
<tr>
<td>9A</td>
<td>OTHER INSURED'S POLICY OR GROUP NUMBER</td>
</tr>
<tr>
<td>9B</td>
<td>RESERVED FOR NUCX USE</td>
</tr>
<tr>
<td>9C</td>
<td>RESERVED FOR NUCX USE</td>
</tr>
<tr>
<td>10</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
<tr>
<td>10A-D</td>
<td>IS PATIENT'S CONDITION RELATED TO:</td>
</tr>
<tr>
<td>10A</td>
<td>Select whether the patient's condition is related to employment</td>
</tr>
<tr>
<td>10B</td>
<td>Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation</td>
</tr>
<tr>
<td>10C</td>
<td>Select whether the patient's condition is related to any other type of accident</td>
</tr>
<tr>
<td>10D</td>
<td>CLAIM CODES (DESIGNATED BY NUCC)</td>
</tr>
</tbody>
</table>

### PATIENT'S DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

- up to 11 additional ICD-CM codes can be entered.

### PATIENT'S SURVIVING OR AUTHORIZED PERSON'S SIGNATURE

- Must be dated, using an eight-digit date format (MM/DD/CCYY).

### SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS

- Must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY). Should match rendering provider signature - Field 24J.

### SERVICE FACILITY LOCATION INFORMATION

- Required when different from Billing Provider. Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.

### SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS

- The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY). Should match rendering provider signature - Field 24J.
Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

7  Anesthesia information
ZZ  Narrative description of unspecified code
N4  National Drug Codes (NDC)
VP  Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard
OZ  Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
CTR  Contract rate

For additional information for reporting NDC units, see the National Uniform Claim Committee’s website at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured’s prefix and identification number in Field 1a.
- Put the physician or supplier’s billing name, address, zip code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

For information on submitting claims electronically, visit:
https://www.lifethc.com/vendors/consentforms.html

For additional information on Place of Service Codes visit:
http://www.cms.gov/Medicare/Coding/place-of-service-codes/