

Illustration 1-1. Revised CMS-1500 Claim Form (front)

1500

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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 (MM DD YY) SEX (M F)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)	
8. PATIENT STATUS (Single Married Other)		7. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: (Employed Full-Time Student Part-Time Student)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		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. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? (YES NO)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER	
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.)	
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)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO) (MM DD YY)	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? (YES NO) \$ CHARGES	
24. A. DATE(S) OF SERVICE (From To) (MM DD YY MM DD YY)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
B. PLACE OF SERVICE (EMG)		23. PRIOR AUTHORIZATION NUMBER	
C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS MODIFIER)		24. E. DIAGNOSIS POINTER	
D. \$ CHARGES		F. \$ CHARGES	
E. DAYS OF UNITS		G. H. I. J.	
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.)		32. SERVICE FACILITY LOCATION INFORMATION (a. NPI b.)	
33. BILLING PROVIDER INFO & PH # () (a. NPI b.)			

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Incorporated by reference in 59G-4.001, F.A.C.

Illustration 1-2. Revised CMS-1500 Claim Form (back)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the *Federal Register*, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," *Federal Register* Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Incorporated by reference in 59G-4.001, F.A.C.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
1	Medicare and Medicaid	<p>For an initial claim submission, enter an “X” in the applicable boxes.</p> <p>If the patient is eligible for Medicaid only, enter an “X” in the Medicaid box.</p> <p>For Medicare-Medicaid crossover claims, enter an “X” in both the Medicare and Medicaid boxes and attach the EOMB.</p> <p>To request an ADJUSTMENT or VOID to the most recently paid Medicaid claim, enter an “A” or “V” in the Medicaid box. Enter the 13-digit Internal Control Number (ICN) assigned to the paid claim in the upper left corner, above the top line of the form. For a legacy claim that the prior Medicaid fiscal agent processed that has a 17-digit Transaction Control Number (TCN), enter the TCN.</p> <p>The ICN can be found on the remittance advice that reported the incorrect payment. For a claim that was adjusted, but still has not paid correctly, use the ICN of the last adjustment that paid.</p> <p>If the ICN does not appear on the top of the claim form and an “A” or “V” is entered in the Medicaid box, the adjustment or void request cannot be processed and will be returned to the provider.</p> <p><u>Note:</u> See Chapter 2 in this handbook for additional information on adjustments and voids. See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare-Medicaid crossover claims.</p> <p><u>Note:</u> See Appendix A for the Internal Control Number (ICN) Regions Codes.</p>
1a	Insured’s ID Number	<p>Enter the recipient’s ten-digit Medicaid Identification (ID) Number. Do not enter the eight-digit number on the Medicaid ID card. This is a card control number, not the recipient’s Medicaid ID number.</p> <p>For Medicare crossover claims, enter the Medicare Identification number in this item.</p> <p><u>Newborn Billing:</u> See Presumptively Eligible Newborns in Chapter 3 of the Florida Medicaid Provider General Handbook.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
2	Patient's Name	Enter the recipient's last name, first name, and middle initial exactly as it appears on the Medicaid Identification Card or other proof of eligibility.
3	Patient's Birth Date	Enter the recipient's date of birth in eight-digit month, day, year format (MM/DD/CCYY). Example: for August 21, 1997, enter 08/21/1997.
	Patient's Sex	Use an "X" to mark the appropriate box, male or female.
4	Insured's Name	No entry required unless the recipient is covered by other insurance. If there is other insurance, enter the name of the insured. If the insured and the patient are the same person, enter the word "SAME."
5	Patient's Address	No entry is required, but the information may be helpful to identify a recipient if the Medicaid ID number is incorrect.
6	Patient's Relationship to Insured	No entry required.
7	Insured's Address	No entry required unless the recipient is covered by other insurance.
8	Patient Status	No entry required.
9a-d	Other Health Insurance Coverage	Enter the requested information if the recipient has other insurance. In field 9d, enter the primary insurance plan name; do not enter the name of the insurance agency or agent. Attach the Explanation of Benefits (EOBs) for the primary insurance and any other insurers. Enter the word "none" or "not applicable" if there is no other insurance coverage. If the patient has Medicare coverage, bill Medicare first. <u>Note:</u> See Chapter 4 in the Florida Medicaid Provider General Handbook for information on Medicare crossover claims. See Chapter 2 in this handbook for information on billing Medicaid when there is a discount contract.
10a-c	Is Patient's Condition Related to:	Enter an "X" in any part(s) that apply and give corresponding information in Item 10a-c.
10d	Reserved for Local Use	No entry is required for Medicaid only billing. For Medicare crossover claims, enter the recipient's ten-digit Medicaid ID number.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
11a-d	Insured's Group No.	No entry required.
12	Patient's or Authorized Person's Signature	No entry required.
13	Insured's or Authorized Person's Signature	No entry required.
14	Date of Current Illness, Injury or Pregnancy	No entry required.
15	Dates of Same or Similar Illness	No entry required.
16	Dates Patient Unable to Work	No entry required.
17	Name of Referring Provider or Other Source	<p>Enter the name (first, middle initial and last) and credentials of the professional who referred or ordered the service(s) or supply(s) being billed on the claim.</p> <p>Do not use periods or commas within the name. A hyphen can be used for hyphenated names.</p> <p>For example: Jane A Smith MD</p> <p>The referring provider and treating provider cannot be the same individual. A MediPass primary care provider must leave this item blank if he personally rendered the service.</p> <p>Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass primary care provider, or did not require service authorization.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
17a	Qualifier and Other Provider ID Number (Shaded Area) for the Referring Provider	<p>This item consists of two fields: one small field to the right of the item number 17a, followed by a larger field.</p> <p>In the small field, enter the qualifier code that indicates what the number in the large field represents. The qualifier codes are used to identify a number that is not an NPI number. The qualifier codes used with Medicaid claims are:</p> <p>9F MediPass Referral or Service Authorization Number 1D Medicaid Provider Number ZZ Provider Taxonomy</p> <p>MediPass: For a procedure that requires a MediPass referral, enter qualifier code 9F in the small field to the right of 17a, and enter the MediPass primary care provider's nine-digit authorization number in the large field.</p> <p>The referring provider and treating provider cannot be the same individual. MediPass primary care providers must leave this item blank for services that they personally rendered.</p> <p>MediPass referral numbers did not change when NPI was implemented. Continue to enter the MediPass referral number in Field 17a and leave field 17b blank.</p> <p>Medical Foster Care and Prescribed Pediatric Extended Care Centers: For services that are authorized after July 1, 2008, Medical Foster Care and Prescribed Pediatric Extended Care Center providers will receive a prior authorization number from the Medicaid fiscal agent instead of a service authorization number from the area Medicaid office service authorization nurse. For services for which the provider received a prior authorization number from the Medicaid fiscal agent, enter the prior authorization number in field 23.</p> <p>For services authorized prior to July 1, 2008, enter qualifier code 9F in the small field to the right of 17a, and enter the service authorization number in the large field.</p> <p>(Continued)</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
17a	Qualifier and Other Provider ID Number for the Referring Provider (Continued)	<p>Project AIDS Care Home and Community-Based Waiver Services: Enter qualifier code 9F in the small field to the right of 17a, and enter the service authorization number in the large field.</p> <p>Targeted Case Management Services: No entry is required.</p> <p>Referral Procedures: For a non-MediPass or service authorization referred procedure, such as a consultation, enter qualifier code 1D in the small field to the right of 17a, and enter the referring physician's nine-digit Medicaid provider number in the large field.</p> <p>If the referring physician is not a Medicaid provider, enter the physician's name in field 17 and qualifier code 1D and pseudo provider number 000000100 in field 17a.</p> <p>You may enter either qualifier code 1D and the Medicaid provider number in 17a or the NPI number in 17b. If you enter the NPI in 17b and the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ in the small field and enter the referring physician's taxonomy in the large field of 17a. Florida Medicaid recommends that you enter the Medicaid provider number on paper claims.</p> <p>Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass primary care provider, or did not require service authorization.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM TITLE ITEM	ACTION
17b NPI	<p>Enter either qualifier code 1D and the Medicaid provider number in 17a or the NPI number in 17b. If you enter the NPI in 17b and the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, in item 17a, enter qualifier code ZZ in the small field and enter the referring physician's taxonomy in the large field of 17a. Florida Medicaid recommends that you enter the Medicaid provider number on paper claims.</p> <p style="text-align: center;">For MediPass and service authorization referrals, leave item 17b blank and enter the referral number in item 17a.</p>

Summary of Items 17a and Item 17b:

Type of Referral	Field	Qualifier	Data Requested
MediPass referral	17a	9F	MediPass primary care provider's nine-digit authorization number
	17b	NPI	Blank
Service Authorization	17a	9F	For Project AIDS Care waiver services, enter qualifier 9F and the service authorization number in field 17a.
			For Medical Foster Care and PPEC services that are authorized after July 1, 2008, providers will receive a prior authorization number from the Medicaid fiscal agent instead of a service authorization number from the area Medicaid office service authorization nurse. Enter the prior authorization number in field 23.
	17b	NPI	Blank
Referral Procedures	17a	Enter either qualifier 1D and the Medicaid provider number in 17a or enter the NPI in 17b. If you enter the NPI in 17b, leave 17a blank unless the taxonomy is needed to identify the referring physician in the Medicaid claims processing system. If yes, enter qualifier ZZ and the taxonomy in 17a. Florida Medicaid recommends that you enter the Medicaid provider number on paper claims.	
	17b	NPI	Referring physician's NPI
Treatment by PCP	17a	None	Leave blank if care was provided by the primary care provider.
	17b	NPI	Blank

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
18	Hospitalization Dates Related to Current Services	No entry is required, but an entry is preferred.
19	Reserved for Local Use	No entry required. Keyed claim type has been eliminated
20	Outside Lab	No entry required.
21	Diagnosis or Nature of Illness or Injury	<p data-bbox="613 600 1419 814">Enter the patient's diagnosis code(s). List up to four ICD-9-CM diagnosis codes in priority order (primary, secondary condition). The primary diagnosis code must be entered first, because it may be linked to the procedure code in the Medicaid claims processing system. Relate lines 1, 2, 3, 4 to the lines of service in 24E by the line number. Use the highest level of specificity. Do not provide narrative description in this field.</p> <p data-bbox="613 848 1419 966">When entering the diagnosis code, use the space containing a period already printed on the form to separate the two sets of numbers. Diagnosis codes with an "E" or "M" prefix cannot be used for billing Medicaid.</p> <p data-bbox="613 999 1349 1087">Certain diagnosis codes are identified as emergency diagnosis codes. A copayment is not deducted for services using these diagnosis codes.</p> <p data-bbox="613 1121 1419 1146">Ambulance, Wheelchair and Stretcher Vans: No entry is required.</p> <p data-bbox="613 1167 1230 1192">Child Health Check-Up: Enter a diagnosis code(s).</p> <p data-bbox="613 1213 1344 1272">Home and Community-Based Waiver Services: No entry is required.</p> <p data-bbox="613 1293 1419 1591">Independent Laboratories: Enter a diagnosis only for limited coverage procedures. Labs must enter the diagnosis code from the referring provider when filing claims for MediPass exempt services, family planning waiver services, and genetic testing. See the Florida Medicaid Independent Laboratory Services Coverage and Limitations Handbook for the procedure codes and required diagnosis codes. The handbook is available on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, and then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.190, F.A.C.</p> <p data-bbox="613 1612 1419 1701">Physician Specialties: 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).</p> <p data-bbox="613 1722 1224 1747">Targeted Case Management: No entry is required.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
22	Medicaid Resubmission Code	No entry required. See instructions in claim item 1 for submitting voids and adjustments to paid claims.
23	Prior Authorization Number	If the service required prior or post authorization, enter the ten-digit authorization number from the approval letter. Claims for prior and post authorized services are subject to service limitations and the 12-month filing limit.

Do not use this field to enter a MediPass referral number.

Medical Foster Care and Prescribed Pediatric Extended Care Centers: For services that are authorized after July 1, 2008, providers will receive a prior authorization number from the Medicaid fiscal agent instead of a service authorization number from the area Medicaid office service authorization nurse. Enter the prior authorization number in this field. Continue to report the service authorization number on claims for services for which the provider had received a service authorization number from the area Medicaid office service authorization nurse in field 17a.

MediPass and service authorization referral numbers are entered in item 17a.

Ambulance, Wheelchair and Stretcher Vans: Although certain services must be prior authorized, there is no required entry in this item. See Chapter 2 in the Florida Medicaid Ambulance Services Coverage and Limitations Handbook for the prior authorization requirements.

Home and Community-Based Waiver Services: No entry is required.

Home Health Services: If home health visits were pre-approved, enter the ten-digit authorization number from the approval letter.

Note: See Prior Authorizations in Chapter 3 for information on obtaining authorization for services.

Note: See the service-specific Coverage and Limitations Handbook or the Florida Medicaid Provider Reimbursement Schedule for service limitations and the services that require prior authorization. The handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, and then Provider Support, and then on Provider Handbooks. The handbooks for Medicaid state plan services are incorporated by reference in the Medicaid Services Rule Chapter, 59G-4, F.A.C. The handbooks for waiver services are incorporated by reference in the Medicaid Waiver Programs Rule Chapter, 59G-13, F.A.C.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24	Section 24 A—J	<p>The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The shaded area at the top of each of the six claim lines is used to report supplemental information. The shaded area cannot be used to bill for additional services.</p> <p>Supplemental information is placed in the shaded section of 24A through 24G, as defined in each item number. The shaded areas of lines 1 through 6 allow for the entry of 61 characters, from the beginning of 24A to the end of 24G.</p>
24 A	Date(s) of Service	<p>Enter date(s) of service, From and To, in the unshaded area. If there is one date of service only, enter that date under the From date, and leave the To date blank. If the procedure allows consecutive day billing and is provided for more than one consecutive day, enter the last date of service in the To date.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Exceptions: Home and Community-Based Waiver Services: For procedures that are based on a monthly unit of service, under the From date, enter the last day of the month in which the recipient received the service. However, if the recipient was admitted to a hospital or a nursing facility, enter the day before the recipient's admission or the claim will deny.</p> <p>Targeted Case Management: For procedures that are based on a monthly unit of service, under the From date, enter the last day of the month in which the recipient received the service. However, if the recipient was admitted to a hospital or a nursing facility, enter the day before the recipient's admission or the claim will be denied.</p> </div> <p>Enter dates in a month, date, year format (MM/DD/YY) using six digits. For example, for January 8, 2007, enter 01/08/07.</p> <p>All services, except those listed below, must be billed with one date of service entered in the From date, per claim line. The To date is not necessary.</p> <p>(Continued)</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 A (continued)	Date(s) of Service	<p>Assistive Care Services (ACS) Providers: Enter the range of dates when services were provided based on facility documentation. If a recipient received ACS on each day of the month without any hospitalization, nursing facility admission, or leave from the facility, then the first date of service will correspond to the first day of the month and the last date of service will correspond to the last day of the month. If the recipient received services in the facility, then left the facility for any reason and returned within the same month, use more than one claim line to show the actual billable dates of service.</p> <p>DME and Medical Supplies Providers: The date an item is made available to the recipient is the date of service. Procedure codes that pay a daily reimbursement (E0202, E0618, E0619, E0781, E0791 and E0935) require From—To dates of service. The dates must be within the same month. Subsequent months must be billed on new claim lines.</p> <p>For orthotics and prosthetics (“L” procedure codes), the date of service is the date the item is ordered. “L” procedure codes must be billed after the device is fitted.</p> <p>For customized wheelchairs the date of service is the date on the letter from the fiscal agent that approves the prior authorization request. The item may not be billed until after the wheelchair has been delivered to the recipient.</p> <p>For rental items:</p> <ul style="list-style-type: none"> • For the first DME rental claim, the date the item is delivered or made available to the recipient is the date of service. • Subsequent rental claims may be submitted monthly. • For partial month rental payment, see the Florida Medicaid Durable Medical Equipment Medical Supply Services Coverage and Limitations Handbook. <p>End-Stage Renal Disease-Related Services: Services rendered for a monthly period, or for consecutive days within one month, may be billed on one line with a From date and a To date.</p> <p>Hearing aids: The date of service for all services is the date the device is ordered from the manufacturer.</p> <p>(Continued)</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 A (continued)	Date(s) of Service	<p>Independent Laboratory: The date of service is the date the tests were ordered on the laboratory service form.</p> <p>Medical Foster Care Providers: Services rendered in one calendar month may be billed on one line with a From date and a To date. Services provided during different months must be billed on separate lines. If there is a break in the provision of services, begin a new line. If the child's level of reimbursement changes, a separate line must be completed for each level of care provided.</p> <p>Physicians, advanced registered nurse practitioners and physician assistants: Hospital visits that are rendered on consecutive days in one calendar month can be billed on one line with a From date and a To date.</p> <p>Prescribed Pediatric Extended Care (PPEC) Providers: Services rendered in one calendar week may be billed on one line with a From date and a To date.</p> <p>Prosthetic Eyes: The date of service is the date the provider ordered the eye.</p> <p>Regional Perinatal Intensive Care Centers (RPICC): Enter the admission date in the From date and the date of discharge in the To date. The date of discharge is not reimbursed.</p> <p>Visual Services: The provider must use the date that the eyeglasses were dispensed as the date of service on the claim when billing for the eyeglasses (frames, lenses, and add-ons). An exception is if the recipient was ineligible for Medicaid when the eyeglasses are dispensed, the provider may use the date that the eyeglasses were ordered as the date of service when submitting the claim.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 B	Place of Service	<p>Enter the two-digit place of service (POS) code in the unshaded area for each procedure performed. The Place of Service Code identifies the location where the service was rendered.</p> <p>Ambulances and Wheelchair and Stretcher Vans: No entry required. There is no applicable POS code.</p> <p><u>Note:</u> See Place of Service Codes in this chapter for the correct place of service codes.</p>
24 C	EMG	<p>If the service was an emergency, enter a “Y” for yes in the unshaded area of the field. If the service was not an emergency, leave the item blank.</p> <p>A Medicaid copayment will not be deducted if the service provided was an emergency.</p> <p>Authorization from the MediPass primary care provider is not required if a MediPass recipient has an emergency medical condition.</p> <p><u>Note:</u> See the definitions of emergency and emergency care and services in the Glossary in the Florida Medicaid Provider General Handbook.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 D	Procedures, Services or Supplies: CPT/HCPCS and Modifiers	<p>In the unshaded area, enter the CPT or HCPCS code and modifier(s) from the appropriate code set in effect on the date of service. The specific procedure code(s) must be shown without a narrative description.</p> <p>The allowable procedure codes are listed either on the Medicaid fiscal agent's Web Portal at http://mymedicaid-florida.com (click on Public Information for Providers, and then Provider Support, and then on Fee Schedules) or in the Medicaid service-specific Coverage and Limitations Handbook.</p> <p>Modifiers: For certain types of service, a modifier must be entered after the procedure code. Refer to the Medicaid service-specific Coverage and Limitations Handbooks for a list of covered codes and special instructions for using modifiers required to uniquely identify some Medicaid services. The modifier field accommodates the entry of up to four two-digit modifiers.</p> <p>Modifier 99 is used when two or more pricing modifiers are applicable to one procedure code line. Do not use modifier 99 when the procedure code has two local-code modifiers. Use of modifier 99 requires claim review by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code.</p> <p>Entering a pricing modifier and local-code modifier: If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first modifier field on the claim form, and enter the local-code modifier in the second modifier field.</p> <p>By Report: By report procedures are procedures that must be approved or manually priced. They must be submitted on paper claims forms with relevant reports attached. Procedure codes with modifier 99, procedure codes marked "R" on the Provider Fee Schedules, and other procedures specified in the Medicaid service-specific Coverage and Limitations Handbooks and the Provider Fee Schedules are approved and priced by report.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION																																																											
24 D (continued)	Procedures, Services or Supplies: CPT/ HCPCS Codes and Modifiers	<p>HCPCS Codes for Drugs: Providers who bill HCPCS codes for drugs must enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in the shaded area of item 24. Begin entering the information above 24 A. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.</p> <p>The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See Chapter 4 in the Florida Medicaid Provider General Handbook for instructions for crossover claims for J3490, Unclassified Drugs, and J9999, Not Otherwise Assigned, Antineoplastic Drugs.</p> <p>Florida Medicaid will only reimburse for drugs for which the manufacturer has a federal rebate agreement per Section 1927 of the federal Social Security Act [42 U.S.C. 1396r-8]. The current list of manufacturers who have drug rebate agreements is available on AHCA’s website at http://ahca.myflorida.com. Click on Medicaid, scroll down to “What is Occurring in Medicaid,” and then click on “Current List of Drug Rebate Manufacturers.”</p> <p>The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer’s labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:</p> <ul style="list-style-type: none"> • For a 4-4-2 digit number, add a 0 to the beginning • For a 5-3-2 digit number, add a 0 as the sixth digit. • For a 5-4-1 digit number, add a 0 as the tenth digit. <p>Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:</p> <p style="padding-left: 40px;">F2 – International Unit GR – Gram ML – Milliliter UN – Unit</p> <table border="1" data-bbox="662 1675 1393 1787"> <tr> <td colspan="6">24. A. DATE(S) OF SERVICE</td> <td>B.</td> <td>C.</td> <td colspan="4">D. PROCEDURES, SERVICES, OR SUPPLIES</td> </tr> <tr> <td colspan="6">From To</td> <td>PLACE OF SERVICE</td> <td>EMG</td> <td colspan="4">(Explain Unusual Circumstances)</td> </tr> <tr> <td>MM</td> <td>DD</td> <td>YY</td> <td>MM</td> <td>DD</td> <td>YY</td> <td></td> <td></td> <td>CPT/HCPCS</td> <td colspan="3">MODIFIER</td> </tr> <tr> <td colspan="6">N400026064871UN1284</td> <td></td> <td></td> <td>J1568</td> <td></td> <td></td> <td></td> </tr> <tr> <td>10</td> <td>01</td> <td>05</td> <td>10</td> <td>01</td> <td>05</td> <td>11</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)				MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			N400026064871UN1284								J1568				10	01	05	10	01	05	11				
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How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 D (continued)	Procedures, Services or Supplies: CPT/ HCPCS Codes and Modifiers	Ambulances and Wheelchair and Stretcher Vans: In the first modifier field, enter both the origin modifier and the destination modifier. The field holds two alpha characters. Do not enter the destination modifier in the second modifier field.

The origin and destination modifier codes are as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than P or H
E	Residential, domiciliary, custodial facility (nursing home, not a skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between types of ambulance
J	Non-hospital based dialysis
N	Skilled nursing facility (SNF)
P	Physician's office, which includes HMO non-hospital facility, clinic, etc.
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at the physician's office in route to hospital (includes HMO non-hospital facility, clinic, etc.). Modifier X can be entered only in the second modifier field.

In the second modifier field, enter the following pricing modifier(s), if applicable:

- Modifier QN, when submitting a claim for a negotiated rate; and
- Modifier 76, when the same provider bills the same procedure code and origin and destination modifier for the same recipient, on the same date of service.

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 E	Diagnosis Pointer	<p>Enter the diagnosis code reference number (pointer) from Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter the reference number in the unshaded area left justified in the field. (Do not enter the ICD-9-CM number in this item. It can be entered only in Item 21.)</p> <p>Enter only one reference number per line item unless instructed otherwise in the service-specific Coverage and Limitations Handbook.</p> <p>If more than one diagnosis reference is required by the Medicaid service-specific Coverage and Limitations Handbook, you must use a comma (,) separator between the diagnosis code pointers.</p> <p>When multiple services are performed, enter the primary reference number for each service (either "1", "2", "3", or "4").</p> <p>Ambulance, Wheelchair and Stretcher Vans: No entry is required.</p> <p>Home and Community-Based Waiver Services: No entry is required.</p> <p>Targeted Case Management: No entry is required.</p>
24 F	Charges (Unshaded Area)	<p>Enter the usual and customary charge for the procedure performed. Enter the dollar amount in the unshaded area, right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Do not enter dollar signs or negative dollar amounts. Enter the cent amount in the cent area of the field. Enter 00 in the cents area if the charge is a whole number. The decimal must be included. For example: 250.00.</p> <p>This item allows for the entry of six characters to the left of the vertical line and two characters to the right of the vertical line.</p> <p>Assistive Care Services Provider: For each line used, enter the total of the payment rate times the number of days shown on that line.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 G	Days or Units (Unshaded Area)	<p>Enter the units of service rendered or number of days that the service was rendered for each detail line in the unshaded area. A unit of service is the number of times a procedure is performed. When only one procedure is performed, enter a “1” in the item. If a procedure code for consecutive days is billed on one claim line using the From—To dates, enter the appropriate number of units in item 24G.</p> <p>Home and Community-Based Waiver Services: Enter the units of service rendered for the procedure code. If multiple units of the same procedure were performed on the same date of service, enter the total number of units. If the date of service covers a span of time, i.e., a month, enter the total number of units for that span of time.</p> <p>Targeted Case Management: Enter the units of service rendered for the procedure code. If multiple units of the same procedure were performed on the same date of service, enter the total number of units. If the date of service covers a span of time, i.e., a month, enter the total number of units for that span of time.</p> <p>The definition of unit varies by service. Please see the service-specific Coverage and Limitations Handbook for information on how to compute a unit of service.</p> <p>Enter the numbers right justified in the field. Do not use leading zeros.</p>
24 F	Third Party Coverage (Shaded Area)	<p>Third Party Coverage: If payment from a primary insurance carrier is expected or already received, enter the identifier IP for Individual Policy or GP for Group Policy and enter the paid or expected amount in the shaded area of Items 24 F and G.</p> <p>Do not enter payments received from Medicare.</p> <p>Do not enter payments received from Medicaid copayments.</p> <p>Do not use commas when reporting dollar amounts. Do not enter dollar signs or negative dollar amounts. Enter 00 if the charge is a whole number. The decimal must be included. For example: 250.00.</p> <p>If no payment was received or if the service was denied, leave the item blank and attach a copy of the explanation of benefits (EOB) from the insurance carrier that indicates the reason for the denial to the claim.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION								
24 H	EPSDT and Family Planning Indicator (Unshaded Area)	<p>This item allows for the entry of one character in the unshaded area.</p> <p>Enter an “E” if the patient was referred for the services as a result of a Child Health Check-Up screening. (Child Health Check-Up was formerly named EPSDT.) If the service is a surgery that was referred as a result of a Child Health Check-Up screening, an “E” in this item will indicate to the system that prior authorization was not required.</p>								
	Child Health Check-Up Referral Code Indicator	<p>If the service is a Child Health Check-Up, enter the referral code that identifies the health status of the child:</p> <table border="1" data-bbox="607 747 1385 1211"> <tbody> <tr> <td data-bbox="618 747 695 810">V</td> <td data-bbox="708 747 1385 810">Patient Refused Referral/Available Not Used Indicator is used when the patient refused a referral.</td> </tr> <tr> <td data-bbox="618 814 695 877">U</td> <td data-bbox="708 814 1385 877">Patient Not Referred/Not Used Indicator is used when there are no referrals made.</td> </tr> <tr> <td data-bbox="618 882 695 999">2</td> <td data-bbox="708 882 1385 999">Under Treatment Indicator is used when patient is currently under treatment for referred diagnostic or corrective health problem.</td> </tr> <tr> <td data-bbox="618 1003 695 1211">T</td> <td data-bbox="708 1003 1385 1211">New Services Requested Indicator is used for referrals to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic check-up (not including dental referrals).</td> </tr> </tbody> </table>	V	Patient Refused Referral/Available Not Used Indicator is used when the patient refused a referral.	U	Patient Not Referred/Not Used Indicator is used when there are no referrals made.	2	Under Treatment Indicator is used when patient is currently under treatment for referred diagnostic or corrective health problem.	T	New Services Requested Indicator is used for referrals to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic check-up (not including dental referrals).
V	Patient Refused Referral/Available Not Used Indicator is used when the patient refused a referral.									
U	Patient Not Referred/Not Used Indicator is used when there are no referrals made.									
2	Under Treatment Indicator is used when patient is currently under treatment for referred diagnostic or corrective health problem.									
T	New Services Requested Indicator is used for referrals to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic check-up (not including dental referrals).									
	Family Planning Indicator	<p>Enter an “F” if the services relate to a pregnancy or if the services were for family planning.</p> <p>If the service requires a copayment, an “F” in this item will indicate that the recipient received a pregnancy-related service or family planning, and the copayment will not be deducted from the provider’s reimbursement.</p>								

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 H	Shaded Area	Hospice: For all recipients in hospice, enter “H” in the shaded area of Item 24H.
24 I	ID Qualifier— Shaded Area	<p>Enter the individual rendering (treating) provider’s qualifier code in the shaded area of item 24 I. The rendering provider’s other ID number is reported in item 24 J in the shaded area. Enter the rendering provider’s ID number only when it is different from the pay-to provider number that is entered in items 33a or 33b.</p> <p>If entering the rendering provider’s Medicaid provider number, enter qualifier code 1D.</p> <p>If entering the rendering provider’s NPI and the NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code in the shaded area of item 24 J.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
24 J	Rendering Provider ID #	<p>Treating Provider: Enter the individual rendering (treating) provider's number in Item 24 J. Enter the rendering provider's ID number only when it is different from the pay-to provider number that is entered in items 33a or 33b.</p> <p>Entry of NPI on paper claims is optional. Florida Medicaid recommends that you continue to enter Medicaid provider numbers on paper claims.</p> <p>If entering the rendering provider's NPI and if the rendering provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code in the shaded area of item 24 I and enter the taxonomy code in the shaded area of item 24 J.</p> <p>If more than one treating provider in the group rendered services to the same recipient on the same date of service, enter the number for the treating provider who actually rendered the service on the claim line.</p> <p>Early Intervention Services: When the provider number in item 33 is a group number, enter the individual treating provider's number. Services rendered by professional and paraprofessional staff cannot be billed on the same claim form.</p> <p>Child Health Check-Up: When the provider number in item 33 is a group number, enter the Child Health Check-Up treating provider's number in 24J.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
25	Federal Tax ID Number	No entry required.
26	Patient's Account Number	The provider may enter a recipient account number so that it will appear on the remittance advice. Any letter or number combination up to 10 digits may be entered. Enter the numbers left justified in the field.
27	Accept Assignment	No entry required.
28	Total Charge	<p>Add together all charges in the column under item 24F, and enter the total amount in this item in dollars and cents format, i.e., 250.00.</p> <p>Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Do not enter dollar signs. Enter 00 in the cents area if the amount is a whole number.</p> <p>This field allows for the entry of seven characters to the left of the vertical line and two characters to the right of the vertical line.</p>
29	Amount Paid	<p>Enter the amount paid by other health insurance coverage if applicable. This amount must equal the total of the TPL entries in shaded area of column 24 F. The amount must be entered in dollar and cents format, including the decimal. For example: 250.00.</p> <p>Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Do not enter dollar signs. Enter 00 in the cents area if the amount is a whole number.</p> <p>This field allows for the entry of six characters to the left of the vertical line and two characters to the right of the vertical line.</p> <p>Do not enter prior Medicaid payments here when filing an adjustment invoice.</p> <p>Do not enter Medicare payments here when filing a Medicare and Medicaid crossover claim.</p> <p>Do not enter the Medicaid copayment amount in this item.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
30	Balance Due	No entry required.
31	Signature of Physician or Supplier Including Degrees or Credentials and Date	<p>Sign and date the claim form. If the provider uses a facsimile signature or a signature stamp, the entry must be initialed. The provider is responsible for ensuring that the signature on the claim is that of an authorized individual.</p> <p>The authorized signature certifies that the information entered on the claim is in conformance with the conditions on the back of the claim form and with all federal and state laws and regulations. State laws and regulations include the regulations applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA. Providers are responsible for all claims billed using their Medicaid provider identification numbers. (See Electronic Claims Submissions in this chapter for information on electronic claim certification.)</p> <p>“Signature on file” may be used only if the provider’s billing agent or authorized designee has a written attestation signed by the provider that allows the billing agent or authorized designee to file claims on the provider’s behalf. The attestation must be maintained on file at the billing agent’s or authorized designee’s office. The attestation must be readily available upon AHCA’s request.</p> <p>Enter the date that the form was signed in six-digit format (MM/DD/YY). For example, for January 15, 2007, enter 01/15/07.</p>
32	Service Facility Location Information	<p>Enter the name, address, city, and zip code of the location where the services were rendered in the following format:</p> <p>1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code plus 4.</p> <p>Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main St., #101). Enter a space between the town name and state code; but do not include a comma. When entering a nine-digit zip code, include the hyphen.</p> <p>If services were rendered in the recipient’s home, no entry is required.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
32a	NPI	No entry required.
32b	Other ID#	No entry required.
33	Biller Provider Info & PH #	<p>Item 33 identifies the provider who is requesting to be paid. Enter the billing provider's name, address, zip code and telephone number. Enter the telephone number in the area to the right of the item title. Enter the provider's name and address information in the following format:</p> <p>1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code plus 4</p> <p>Providers must enter the zip code plus 4 in order to be correctly identified in the Medicaid claims processing system.</p> <p>Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main St., #101). Enter a space between the town name and state code; do not include a comma. When entering a nine-digit zip code, include the hyphen.</p>
33a	NPI	<p>Entry of NPI on paper claims is optional. Florida Medicaid recommends that you continue to enter Medicaid provider numbers on paper claims.</p> <p>If entering the pay to provider's NPI, enter it in this field. If the rendering provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code ZZ and the taxonomy code in item 33b.</p> <p>If not entering the NPI, leave blank.</p>

How to Complete the CMS-1500 Claim Form, continued

CLAIM ITEM	TITLE	ACTION
33b	Other ID#	<p>If entering the pay to provider's Medicaid provider number, enter it in this item preceded by the qualifier code 1D (qualifier code 1D stands for Medicaid provider number). Do not enter a space, hyphen, or other separator between the qualifier and Medicaid number. For example: 1D123456789.</p> <p>If entering the pay to provider's NPI in item 33a and if the NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code.</p> <p>If the provider is a group provider, the group number must be entered in item 33, and the individual treating provider number must be entered in item 24 J for each claim line billed.</p> <p>Medicaid payment will be made to the provider whose number is entered in item 33a or 33b. That provider number is used to report Medicaid payments to the IRS. Only one provider number can be entered in claim item 33a or 33b.</p>
33a and 33b	Provider Number	<p>Early Intervention Services: Group providers are assigned two group provider numbers for billing early intervention services: one for services rendered by professional staff and one for services rendered by paraprofessional staff. The provider must bill for services rendered by professional and paraprofessional staff on separate claim forms using the appropriate group provider number.</p> <p>The provider's early intervention services provider number can be used only for early intervention services. If the provider is enrolled in another program, such as therapy services, the provider must use that service-specific provider number for billing those services. A provider cannot bill for different types of Medicaid services on the same claim form.</p>

Place of Service Codes (POS)

Code	Description
03	<p>School A school facility where a recipient receives a Medicaid service.</p>
11	<p>Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, intermediate care facility (ICF), or mobile van where the health professional routinely provides health examination, diagnosis and treatment of illness or injury on an ambulatory basis.</p>
12	<p>Patient's Home Location, other than a hospital or other facility, where the patient receives care in a private residence.</p>
13	<p>Assisted Living Facility Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.</p>
14	<p>Group Home Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.</p>
21	<p>Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non surgical) and rehabilitation services, by or under the supervision of physicians, to patients admitted for a variety of medical conditions.</p>
22	<p>Outpatient Hospital A portion of a hospital that provides diagnostic, therapeutic (both surgical and non surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</p>

Place of Service Codes (POS), continued

Code	Description
23	<p>Emergency Room - Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided on a 24-hour basis.</p>
24	<p>Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.</p>
25	<p>Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.</p>
31	<p>Skilled Nursing Facility A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.</p>
32	<p>Nursing Facility A facility that primarily provides residents with skilled nursing care and related services for rehabilitation of an injured, disabled, or sick person; or on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.</p>
33	<p>Custodial Care Facility A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.</p>
34	<p>Hospice A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.</p> <p><i>Note:</i> This place of service can only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service must be used.</p>

Place of Service Codes (POS), continued

Code	Description
49	<p>Independent Clinic A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.</p>
51	<p>Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.</p> <p>This place of service code is only used for Medicare crossover billing.</p>
53	<p>Community Mental Health Center A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.</p>
54	<p>Intermediate Care Facility for the Developmentally Disabled (IFC-DD) A facility that primarily provides health-related care and services above the level of custodial care to developmentally disabled individuals, but does not provide the level of care or treatment available in a hospital or a skilled nursing facility.</p>
55	<p>Residential Substance Abuse Treatment Facility A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.</p>

Place of Service Codes (POS), continued

Code	Description
57	<p>Non-residential Substance Abuse Treatment Facility A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.</p>
62	<p>Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities.</p>
65	<p>End Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, and maintenance or training to patients or caregivers.</p>
71	<p>State or Local Public Health Clinic A facility maintained by either state or local health departments that provides ambulatory primary care under the general direction of a physician.</p>
72	<p>Rural Health Clinic or Federally Qualified Health Center A certified facility located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.</p>
81	<p>Independent Laboratory A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.</p>
99	<p>Other Unlisted Facility Other service facilities not identified above.</p>

Illustration 1-3. Sample of a Completed CMS-1500 Claim Form with MediPass Referral and Third Party Payment Billing Using the Medicaid Provider Number.

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>											
HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>											
<small>PICA</small> <input type="checkbox"/> <small>PICA</small> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" 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"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doc, Jane						3. PATIENT'S BIRTH DATE MM DD YY SEX 04 27 1956 M F <input checked="" type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME						8. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE					
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 _____						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
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 FROM MM DD YY TO MM DD YY						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 _____					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Jane Smith MD						17a. 09 17b. 012345600 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 620 . 8 3. _____ 2. _____ 4. _____						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/HCP/PCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPROT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # 1 07 06 08 21 58275 1 1P 200.00 1D 765432100 2 _____ _____ _____ _____ _____ _____ _____ _____ 3 _____ _____ _____ _____ _____ _____ _____ _____ 4 _____ _____ _____ _____ _____ _____ _____ _____ 5 _____ _____ _____ _____ _____ _____ _____ _____ 6 _____ _____ _____ _____ _____ _____ _____ _____					
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 850.00 29. AMOUNT PAID \$ 200.00 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.) Charley Jones, MD 07-16-08 SIGNED DATE					
32. SERVICE FACILITY LOCATION INFORMATION Good Samaritan Hospital 13 Main Street Goodtown FL 32301-1234 a. NPI _____ b. _____						33. BILLING PROVIDER INFO & PH # (850) 220-1440 Florida Medical, PA 130 Main Street Goodtown FL 32301-1234 a. NPI _____ b. 1D123456900					
NUCC Instruction Manual available at: www.nucc.org											
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)											

Illustration 1-4. Sample of a Completed CMS-1500 Claim Form For an Injectable Drug with Third Party Payment Billing Using the Provider's NPI

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>																																																																																											
HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>																																																																																											
<small>PICA</small> <input type="checkbox"/> <small>PICA</small> <input type="checkbox"/>																																																																																											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890																																																																																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doc, Jane			3. PATIENT'S BIRTH DATE MM DD YY 04 27 1956			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)																																																																																		
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																		
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER			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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 07 06 08	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. _____ 17b. NPI _____				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Jane Smith MD																																																																																											
19. RESERVED FOR LOCAL USE																																																																																											
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																																																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 620.8 3. _____ 2. _____ 4. _____																																																																																											
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																																											
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">A.</th> <th style="width:10%;">B.</th> <th style="width:10%;">C.</th> <th style="width:10%;">D.</th> <th style="width:10%;">E.</th> <th style="width:10%;">F.</th> <th style="width:10%;">G.</th> <th style="width:10%;">H.</th> <th style="width:10%;">I.</th> <th style="width:10%;">J.</th> </tr> <tr> <th>DATE(S) OF SERVICE</th> <th>PLACE OF SERVICE</th> <th>EMG</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>DIAGNOSIS POINTER</th> <th>\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EPSON Family Plan</th> <th>ID. QUANT.</th> <th>RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>N412345678901UN1234</td> <td>11</td> <td>J1563</td> <td>1</td> <td>1P 250.00 850.00</td> <td></td> <td></td> <td>ZZ</td> <td>207VG0400X 1234567890</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>												A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	DATE(S) OF SERVICE	PLACE OF SERVICE	EMG	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSON Family Plan	ID. QUANT.	RENDERING PROVIDER ID. #	1	N412345678901UN1234	11	J1563	1	1P 250.00 850.00			ZZ	207VG0400X 1234567890	2										3										4										5										6									
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.																																																																																		
DATE(S) OF SERVICE	PLACE OF SERVICE	EMG	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSON Family Plan	ID. QUANT.	RENDERING PROVIDER ID. #																																																																																		
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25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			28. TOTAL CHARGE \$ 850.00																																																																																		
29. AMOUNT PAID \$ 250.00			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.) Charley Jones, MD 07-06-08			32. SERVICE FACILITY LOCATION INFORMATION Good Samaritan Hospital 13 Main Street Goodtown FL 32301-1234																																																																																		
33. BILLING PROVIDER INFO & PH # (850) 220-1440			a. 0987654321			b. ZZ207VG0400X			30. BALANCE DUE																																																																																		
NUC Instruction Manual available at: www.nucc.org																																																																																											
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)																																																																																											

Illustration 1-5. Sample of a Completed CMS-1500 Claim Form For a Project AIDS Care Waiver Service

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>															
HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>															
<small>PICA</small> <small>PICA</small>															
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0987654321									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane						3. PATIENT'S BIRTH DATE MM DD YY 01 31 1955			4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						c. EMPLOYER'S NAME OR SCHOOL NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME						10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, return to and complete item 9 a-d.</i>						
d. INSURANCE PLAN NAME OR PROGRAM NAME						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 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 17a. 9F012345600 17b. NPI						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ 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. S CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #															
1						08 09 08 12 97124 U8 35.00 4 NPI									
2						08 23 08 12 97124 U8 35.00 4 NPI									
3						09 08 08 12 97124 U8 35.00 4 NPI									
4						09 20 08 12 97124 U8 35.00 4 NPI									
5						10 06 08 12 97124 U8 35.00 4 NPI									
6						10 08 08 12 97124 U8 35.00 4 NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN						26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (If provider, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 210.00		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.) Mary Massage 10/22/08 SIGNED DATE						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.									
33. BILLING PROVIDER INFO & PH # Mary's Therapy 4321 Every Street Any City FL 11123-4567						a. NPI b. 1D688817200									
NUCC Instruction Manual available at: www.nucc.org															
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)															

