AmeriHealth

Current and Revised 1500 Claim Forms and Instructions

The National Uniform Claim Committee (NUCC) has released a revised 1500 Claim Form, which is commonly referred to as the CMS-1500. The revised CMS-1500 (08/05) replaces the current CMS-1500 (12/90).

Effective October 1, 2006, we will accept both current and revised 1500 Claim Forms.

The 1500 Claim Form and NPI

Revisions to the 1500 Claim Form include several fields that accommodate the use of your National Provider Identifier (NPI).

Though the revised form accommodates NPI, you must continue to report **current** provider identification numbers in the appropriate shaded areas of the form (17a, 24J, 32b, and 33b) until otherwise notified. Current provider identification numbers must be preceded by a two-character qualifier ID. This qualifier ID is the same as the qualifier ID used when billing electronically. If you do not currently bill electronically, please use the following ID: G2

If you have obtained your NPI(s) and submitted them to us, you may begin to report them **in addition to your current provider identification numbers** on the revised 1500 Claim Form.

If you have any questions regarding the NPI, the application process, or reporting your NPI to us, please contact your Network Coordinator or Provider Services.

Impact to You and Your Practice

In preparation for the acceptance of the revised form, you should arrange for your billing vendors to make any necessary updates to your billing practices. Look to upcoming articles in *Partners In Health Update* for additional details on the CMS implementation date of the revised 1500 Claim Form.

Important Revisions to the 1500 Claim Form

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

Field 17a part 1 and 2	Referring provider's two-character qualifier ID (part 1), followed by the **current** provider identification number (part 2).
Field 17b, part 1	Pre-filled with "NPI."
Field 17b, part 2	Referring provider's NPI.
Field 21, parts 1-4	Diagnosis code fields have been updated to allow four characters of information following the pre-filled decimal point.
Field 24	The shaded area extending from fields 24A through 24G will accommodate supplemental information, such as the narrative description of unspecified codes.
Field 24C	"EMG" (previously "Type of Service"). EMG was previously Field 24I.
Field 24D	"Procedures, Services, or Supplies" has been extended by three characters; you may now record up to four modifiers on the same line.
Field 24E	Now titled "Diagnosis Pointer" (previously "Diagnosis Code"); size decreased by three characters.
Field 24H	"EPSDT Family Plan" decreased in size by one character.
Field 24I	"ID. Qual" (previously "EMG"). The shaded area of this field (part 1) allows you to identify the two-character qualifier ID of the Rendering Provider (Example: G2). The unshaded area (part 2) is pre-filled with "NPI."
Field 24J	"Rendering Provider ID #" (previously "COB"). The shaded area of this field (part 1) allows you to submit the **current** provider identification number of the Rendering Provider that coincides with the two-character qualifier ID reported in the shaded area of 24I (part 1). The unshaded area (part 2) accommodates the Rendering Provider NPI.
Field 32a	Service Facility NPI.
Field 32b	Service Facility two-character qualifier ID and current provider identification number (Example: G21234567002).
Field 33a	Billing Provider NPI (previously "PIN#").
Field 33b	Billing Provider two-character qualifier ID and **current** provider identification number (Example: G21234567001) (previously "GRP#)

Please Note: In addition to the revised fields, we will now require you to populate Field 19 with the ZZ qualifier ID and the Billing Provider's Primary Taxonomy Code (Example: ZZ207LP2900X).

For additional information about the 1500 Claim Form, please visit the NUCC's website at *www.nucc.org*. The NUCC offers a helpful Instruction Manual titled *1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version*, which features walkthroughs of each field of the 1500 Claim Form. You can currently access the guide in PDF form at the following location:
http://www.nucc.org/images/stories/PDF/claim_form_manual_v1-3_7-06.pdf

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CURRENT

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)	1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							ABC1234567800 ← Member I.D. Number (No Suffix for CompSelect®/ Comprehensive Major Medical [CMM])		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M ☒ F ☐	4. INSURED'S NAME (Last Name, First Name		
Doe, John B.				03 20 71			Doe, John B.		
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)		
1234 Main Street				Self ☒ Spouse ☐ Child ☐ Other ☐			1234 Main Street		
CITY		STATE		8. PATIENT STATUS			CITY		STATE
Anytown		NJ		Single ☐ Married ☒ Other ☐			Anytown		NJ
ZIP CODE	TELEPHONE (Include Area Code)			Employed ☐ Full-Time Student ☐ Part-Time Student ☐			ZIP CODE	TELEPHONE (Include Area Code)	
08999	(856) 555-5555						08999	(856) 555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER		
Doe, Mary							15974		
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS)			a. INSURED'S DATE OF BIRTH MM DD YY		SEX
72431				YES ☐ NO ☒			03 20 71	M ☒ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX		b. AUTO ACCIDENT?	PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME		
10 21 70		M ☐ F ☒		YES ☐ NO ☒			Watch Repair, Inc.		
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME		
self-employed				YES ☐ NO ☒			AmeriHealth PPO		
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
HMO, Inc.							YES ☒ NO ☐ If yes, return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
10 28 06		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
Josephine Smith, M.D.	0123456789	11 01 06 TO 11 04 06
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 401 .	3. .	23. PRIOR AUTHORIZATION NUMBER
2. 251 . 8	4. .	123456789 ← Referral/Preauthorization Number

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 02 06	11 02 06	21	6	99205		1	$50 00	1				
2 11 03 06	11 03 06	21	6	20600	25	2	$250 00	1				
3												
4												
5												
6												

Modifier (if applicable)

Provider's Federal Tax ID # (Billing Entity)

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
22-1234567	☐	☒		YES ☐ NO ☐	$ 100 00	$	$

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. HOSPITAL MEDICARE NUMBER AND NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Richard B. Smith, M.D.	ABC Hospital 123 Street Anytown, NJ 08999 1234567002	ABC Medical Group 8 North American Street Anytown, NJ 08999 (856) 555-5555
SIGNED DATE 11/5/06		Provider Individual Number → PIN # 1234567000 GRP # 1234567001 ← Provider Group Number

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90). FORM RRB-1500. APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CAMPUS)

Red items are required by AmeriHealth for payment.
Blue items are required for payment when applicable to the patient's condition/situation.

Black items are optional.

Indicates field required for processing.

1500

HEALTH INSURANCE CLAIM FORM

REVISED

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	X OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	ABC1234567800 ← Member I.D. Number (No Suffix for CompSelect®/ Comprehensive Major Medical [CMM])
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Doe, John B.
3. PATIENT'S BIRTH DATE / SEX	03 20 71 M X / F
4. INSURED'S NAME (Last Name, First Name, Middle	Doe, John B.
5. PATIENT'S ADDRESS (No., Street)	1234 Main Street
6. PATIENT RELATIONSHIP TO INSURED	Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	1234 Main Street
CITY / STATE	Anytown / NJ
8. PATIENT STATUS	Single / Married X / Other
CITY / STATE	Anytown / NJ
ZIP CODE / TELEPHONE (Include Area Code)	08999 / (856) 555-2222
Employed / Full-Time Student / Part-Time Student	
ZIP CODE / TELEPHONE (Include Area Code)	08999 / (856) 555-2222
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Doe, Mary
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	15974
a. OTHER INSURED'S POLICY OR GROUP NUMBER	72431
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH / SEX	03 20 71 M X / F
b. OTHER INSURED'S DATE OF BIRTH / SEX	10 21 70 M / F X
b. AUTO ACCIDENT? / PLACE (State)	YES / X NO
b. EMPLOYER'S NAME OR SCHOOL NAME	Watch Repair, Inc.
c. EMPLOYER'S NAME OR SCHOOL NAME	self-employed
c. OTHER ACCIDENT?	YES / X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	AmeriHealth PPO
d. INSURANCE PLAN NAME OR PROGRAM NAME	HMO, Inc.
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	X YES / NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____

Referring Provider's two-character qualifier ID

Referring Provider's Current Provider ID

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	10 28 06
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM _____ TO _____
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Josephine Smith, M.D.
17a.	G2 0123456789
17b. NPI	999999999
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	FROM 11 01 06 TO 11 04 06
19. RESERVED FOR LOCAL USE	ZZ207LP2900X ← ZZ qualifier ID and Billing Provider's Primary Taxonomy Code
20. OUTSIDE LAB? / $ CHARGES	YES / X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 401 2. 251 8 3. 4.
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	123456789 ← Referral/Preauthorization Number

Referring Provider's NPI

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. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 02 06	11 02 06	21	6	99205		1	$50 00	1		G2 NPI	1234567000 8888888888
2 11 03 06	11 03 06	21	6	20600	25	2	$250 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

Two-character qualifier ID of the Rendering Provider

Modifier (if applicable)

Provider's Federal Tax ID # (Billing Entity)

25. FEDERAL TAX I.D. NUMBER / SSN EIN	22-1234567 / X EIN
26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	
28. TOTAL CHARGE	$ 100 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.)	Richard B. Smith, M.D.
SIGNED / DATE	11/5/06
32. SERVICE FACILITY LOCATION INF	ABC Hospital 123 Street Anytown, NJ 08999
a.	0000001234
b.	G21234567002
33. BILLING PROVIDER INFO & PH #	(856) 555-5555
	ABC Medical Group 8 North American Street Anytown, NJ 08999
a.	2222222222
b.	G21234567001

Service Facility NPI

Service Facility two-character qualifier and Current Provider ID number

Billing Provider NPI

Billing Provider two-character qualifier ID and current provider identification number

NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING

Red items are required by AmeriHealth for payment.
Blue items are required for payment when applicable to the patient's condition/situation.
Black items are optional.

Indicates new field and/or requirement.

Indicates field required for processing.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PARTNERS IN HEALTH UPDATE | OCTOBER 2006 ENCLOSURE

Notes