



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: 1B

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]:

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).

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: 1B). 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: 1B1234567002).
Field 33a	Billing Provider NPI (previously "PIN#").
Field 33b	Billing Provider two-character qualifier ID and current provider identification number (Example: 1B1234567001) (previously "GRP#")

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

PARTNERS IN HEALTH UPDATE | OCTOBER 2006 ENCLOSURE

HEALTH INSURANCE CLAIM FORM											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)					1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) ABC1234567800						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John B.					3. PATIENT'S BIRTH DATE MM DD YY 03 20 71 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F						
5. PATIENT'S ADDRESS (No., Street) 1234 Main Street					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						
CITY Philadelphia			STATE PA		7. INSURED'S ADDRESS (No., Street) 1234 Main Street			CITY Philadelphia		STATE PA	
ZIP CODE 19111		TELEPHONE (Include Area Code) (610) 555-5555			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE 19111		TELEPHONE (Include Area Code) (610) 555-5555		
9. DOE, INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Mary					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
a. OTHER INSURED'S POLICY OR GROUP NUMBER 72431					a. INSURED'S DATE OF BIRTH MM DD YY 03 20 71 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 10 21 70 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M					b. EMPLOYER'S NAME OR SCHOOL NAME Watch Repair, Inc.						
c. EMPLOYER'S NAME OR SCHOOL NAME self-employed					c. INSURANCE PLAN NAME OR PROGRAM NAME Personal Choice						
d. INSURANCE PLAN NAME OR PROGRAM NAME HMO, Inc.					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.					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 _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 10 28 06					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Josephine Smith, M.D.					17a. I.D. NUMBER OF REFERRING PHYSICIAN 0123456789						
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 11 01 06 TO MM DD YY 11 04 06						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES						
1. 401					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
2. 251 8					23. PRIOR AUTHORIZATION NUMBER 123456789 (Referral/Preauthorization Number)						
24. DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSDT Family Plan EMG COB 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. _____											
25. FEDERAL TAX I.D. NUMBER 22-1234567 SSN <input type="checkbox"/> EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Richard B. Smith, M.D.					32. HOSPITAL MEDICARE NUMBER AND NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) ABC Hospital 123 Street Anytown, PA 19003 1234567002						
SIGNED _____ DATE 11/5/06					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # ABC Medical Group 8 North American Street Anytown, PA 19003 (215) 555-5555						
					28. TOTAL CHARGE \$ 100 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$						
					PIN # 1234567000 GRP # 1234567001						

(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 (CHAMPUS)

Green items are required by Independence Blue Cross and its affiliates 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

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

REVISED

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> MEDICARE (Medicare #)		<input type="checkbox"/> MEDICAID (Medicaid #)		<input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN)		<input type="checkbox"/> CHAMPVA (Member ID#)		<input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID)		<input type="checkbox"/> FECA BLK LUNG (SSN)		<input checked="" type="checkbox"/> OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) ABC1234567800					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John B.						3. PATIENT'S BIRTH DATE MM DD YY 03 20 71			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John B.								
5. PATIENT'S ADDRESS (No., Street) 1234 Main Street						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 1234 Main Street							
CITY Philadelphia				STATE PA		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>						CITY Philadelphia				STATE PA			
ZIP CODE 19111		TELEPHONE (Include Area Code) (610) 555-5555				Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>						ZIP CODE 19111		TELEPHONE (Include Area Code) (610) 555-5555					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Mary						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						11. INSURED'S POLICY GROUP OR FECA NUMBER 15974							
a. OTHER INSURED'S POLICY OR GROUP NUMBER 72431						b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)						a. INSURED'S DATE OF BIRTH MM DD YY 03 20 71				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY 10 21 70						c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						b. EMPLOYER'S NAME OR SCHOOL NAME Watch Repair, Inc.							
c. EMPLOYER'S NAME OR SCHOOL NAME self-employed						d. INSURANCE PLAN NAME OR PROGRAM NAME HMO, Inc.						c. INSURANCE PLAN NAME OR PROGRAM NAME Personal Choice							
d. INSURANCE PLAN NAME OR PROGRAM NAME HMO, Inc.						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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.				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 DATE						Referring Provider's Current Provider ID						SIGNED							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 10 28 06				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY 1B 0123456789				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY FROM 11 01 06 TO 11 04 06											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Josephine Smith, M.D.						17a. ID 0123456789		17b. NPI 999999999		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 11 01 06 TO 11 04 06									
19. RESERVED FOR LOCAL USE ZZ207LP2900X						ZZ qualifier ID and Billing Provider's Primary Taxonomy Code		Referring Provider's NPI		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> 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						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						23. PRIOR AUTHORIZATION NUMBER 123456789 Referral/Preauthorization Number							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EXPECTED PAY/Pct		I. ID. QUAL		J. RENDERING PROVIDER ID #			
1 11 02 06 11 02 06		21 6		99205		1		\$50 00		1		1B 1234567000		8888888888					
2 11 03 06 11 03 06		21 6		20600 25		2		\$250 00		1		NPI		Two-character qualifier ID of the Rendering Provider					
												NPI							
												NPI							
												NPI							
												NPI							
												NPI							
												NPI							
25. FEDERAL TAX ID NUMBER 22-1234567				SSN EIN <input checked="" type="checkbox"/>		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.						32. SERVICE FACILITY LOCATION INFO ABC Hospital 123 Street Anytown, PA 19003						33. BILLING PROVIDER INFO & PH # (215) 555-5555 ABC Medical Group 8 North American Street Anytown, PA 19003							
SIGNED DATE 11/5/06						000001234		1B1234567002		2222222222		1B1234567001							

Member I.D. Number (No Suffix for CompSelect/ Comprehensive Major Medical [CMM])

Referring Provider's two-character qualifier ID

Referring Provider's Current Provider ID

ZZ qualifier ID and Billing Provider's Primary Taxonomy Code

Referring Provider's NPI

Referral/Preauthorization Number

Two-character qualifier ID of the Rendering Provider

Modifier (if applicable)

Provider's Federal Tax ID # (Billing Entity)

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

Green items are required by Independence Blue Cross and its affiliates 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.

