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Medicare 101

Module 6: Billing & Reimbursement

Presented by:

CIGNA Government Services

Part B Provider Outreach & Education



CIGNA Government Services

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Objectives

At the end of this module, participants will be able to:

- Properly complete the CMS-1500 form
- Identify common claim submission errors
- Understand the crossover process
- Recognize the elements of the Medicare Remittance Notice (MRN)

Claim Filing Requirement

Omnibus Budget Reconciliation Act of 1989:

- Effective: **September 1, 1990**
- Requires all physicians and suppliers submit claims for Medicare beneficiaries
 - Cannot charge patient for preparing and filing claim

Methods of Claim Submission

All claims must be submitted in an approved format:

- Mandatory Electronic Submission of Medicare Claims
 - Effective October 16, 2003
 - For all *initial* claims submitted to Medicare, with limited exceptions
 - ANSI 4010A1 – Standard
 - Payment floor= 14 days
- Standard CMS-1500 paper claim form
 - Version 08/05, effective July 1, 2007
 - Payment floor= 29 days

Time Limits for Filing Claims

- Medicare accepts claims with dates of service in:
 - Current year (i.e., 2008)
 - Previous year (i.e., 2007)
 - Last quarter of the prior year (i.e., Oct.– Dec. 2006)
- However, if claim is filed more than 12 months from the DOS:
 - Assigned: 10 percent late filing penalty
 - Non-assigned: Referred to CMS for action

Completing the CMS-1500 Form

Version 08/05

Item 1: Type of Health Insurance

Check the "Medicare" box.

| | | | |
|--|--|---|--|
| <div style="border: 1px solid black; padding: 2px; display: inline-block;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small> | | | <small>PICA</small> <small>↑ CARRIER ↓</small> |
| <small> <input type="checkbox"/> PICA </small> | | | <small>PICA</small> <input type="checkbox"/> |
| 1. MEDICARE <input checked="" type="checkbox"/> <small>(Medicare #)</small> MEDICAID <input type="checkbox"/> <small>(Medicaid #)</small> TRICARE CHAMPUS <input type="checkbox"/> <small>(Sponsor's SSN)</small> CHAMPVA <input type="checkbox"/> <small>(Member ID#)</small> GROUP HEALTH PLAN <input type="checkbox"/> <small>(SSN or ID)</small> FECA BLK LUNG <input type="checkbox"/> <small>(SSN)</small> OTHER <input type="checkbox"/> <small>(ID)</small> | | | 1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small> 123456789A |
| 2. PATIENT'S NAME <small>(Last Name, First Name, Middle Initial)</small> Doe, Jane | | 3. PATIENT'S BIRTH DATE <small>MM DD YY</small> 01 01 1938 | 4. INSURED'S NAME <small>(Last Name, First Name, Middle Initial)</small> Same |
| 5. PATIENT'S ADDRESS <small>(No., Street)</small> | | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS <small>(No., Street)</small> |

Item 1a: Insured's ID Number

Enter the patient's Medicare Health Insurance Claim Number (HICN), as it appears on their Medicare card.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| <div style="border: 1px solid black; padding: 2px; display: inline-block;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small> | | | | | | | <small>PICA</small> <small>↑ CARRIER ↑</small> |
| <small>1. MEDICARE</small> <input checked="" type="checkbox"/> <small>(Medicare #)</small> <small>MEDICAID</small> <input type="checkbox"/> <small>(Medicaid #)</small> <small>TRICARE CHAMPUS</small> <input type="checkbox"/> <small>(Sponsor's SSN)</small> <small>CHAMPVA</small> <input type="checkbox"/> <small>(Member ID#)</small> <small>GROUP HEALTH PLAN</small> <input type="checkbox"/> <small>(SSN or ID)</small> <small>FICA BLK LUNG</small> <input type="checkbox"/> <small>(SSN)</small> <small>OTHER</small> <input type="checkbox"/> <small>(ID)</small> | | | | | | <small>1a. INSURED'S I.D. NUMBER</small> <small>(For Program in Item 1)</small> 123456789A | |
| <small>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</small> Doe, Jane | | | <small>3. PATIENT'S BIRTH DATE</small> <small>MM DD YY</small> 01 01 1938 | | <small>SEX</small> <small>M</small> <input type="checkbox"/> <small>F</small> <input checked="" type="checkbox"/> | | |
| <small>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</small> Same | | | <small>5. PATIENT'S ADDRESS (No., Street)</small> | | <small>6. PATIENT RELATIONSHIP TO INSURED</small> | | |
| <small>7. INSURED'S ADDRESS (No., Street)</small> | | | | | | | |

Item 2: Patient's Name

Enter the patient's name as it appears on their Medicare card.

| | | | | | | | | | | | | | | |
|--|----|------|--|--|---|--|---|---|---|----|------|--|---|--|
| <div style="border: 1px solid black; padding: 2px; display: inline-block;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small> | | | | | | | <small>PICA</small> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | |
| <small>1. MEDICARE</small> <input checked="" type="checkbox"/> <small>(Medicare #)</small> | | | <small>MEDICAID</small> <input type="checkbox"/> <small>(Medicaid #)</small> | <small>TRICARE CHAMPUS</small> <input type="checkbox"/> <small>(Sponsor's SSN)</small> | <small>CHAMPVA</small> <input type="checkbox"/> <small>(Member ID#)</small> | <small>GROUP HEALTH PLAN</small> <input type="checkbox"/> <small>(SSN or ID)</small> | <small>FICA BLK LUNG</small> <input type="checkbox"/> <small>(SSN)</small> | <small>OTHER</small> <input type="checkbox"/> <small>(ID)</small> | <small>1a. INSURED'S I.D. NUMBER</small> <small>(For Program in Item 1)</small> 123456789A | | | | | |
| <small>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</small> Doe, Jane | | | | <small>3. PATIENT'S BIRTH DATE</small> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td>MM</td> <td>DD</td> <td>YY</td> </tr> <tr> <td>01</td> <td>01</td> <td>1938</td> </tr> </table> | | MM | DD | YY | 01 | 01 | 1938 | <small>SEX</small> M <input type="checkbox"/> F <input checked="" type="checkbox"/> | <small>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</small> Same | |
| MM | DD | YY | | | | | | | | | | | | |
| 01 | 01 | 1938 | | | | | | | | | | | | |
| <small>5. PATIENT'S ADDRESS (No., Street)</small> | | | | <small>6. PATIENT RELATIONSHIP TO INSURED</small> | | <small>7. INSURED'S ADDRESS (No., Street)</small> | | | | | | | | |

Item 3: Patient's Date of Birth & Gender

Enter the patient's date of birth and gender.

| | | | | | | | | | | | | | | | | | | | |
|--|----|------|--|--|---|--|---|---|---|--|----|----|------|---|---------------------------------------|---|--|--|--|
| <div style="border: 1px solid black; padding: 2px; display: inline-block;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small> | | | | | | | <small>PICA</small> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | |
| <small>1. MEDICARE</small> <input checked="" type="checkbox"/> <small>(Medicare #)</small> | | | <small>MEDICAID</small> <input type="checkbox"/> <small>(Medicaid #)</small> | <small>TRICARE CHAMPUS</small> <input type="checkbox"/> <small>(Sponsor's SSN)</small> | <small>CHAMPVA</small> <input type="checkbox"/> <small>(Member ID#)</small> | <small>GROUP HEALTH PLAN</small> <input type="checkbox"/> <small>(SSN or ID)</small> | <small>FICA BLK LUNG</small> <input type="checkbox"/> <small>(SSN)</small> | <small>OTHER</small> <input type="checkbox"/> <small>(ID)</small> | <small>1a. INSURED'S I.D. NUMBER</small> 123456789A | <small>(For Program in Item 1)</small> | | | | | | | | | |
| <small>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</small> Doe, Jane | | | | <small>3. PATIENT'S BIRTH DATE</small> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr> <td>MM</td> <td>DD</td> <td>YY</td> <td></td> <td></td> </tr> <tr> <td>01</td> <td>01</td> <td>1938</td> <td>M</td> <td>F <input checked="" type="checkbox"/></td> </tr> </table> | | MM | DD | YY | | | 01 | 01 | 1938 | M | F <input checked="" type="checkbox"/> | <small>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</small> Same | | | |
| MM | DD | YY | | | | | | | | | | | | | | | | | |
| 01 | 01 | 1938 | M | F <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| <small>5. PATIENT'S ADDRESS (No., Street)</small> | | | | <small>6. PATIENT RELATIONSHIP TO INSURED</small> | | <small>7. INSURED'S ADDRESS (No., Street)</small> | | | | | | | | | | | | | |

CARRIER

Item 5: Patient Address & Telephone Number

Enter the patient's mailing address and telephone number.

| | | | |
|---|--|--|--|
| <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (COB of ID) (COB) (ID)</small> 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane | | 3. PATIENT'S BIRTH DATE SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 01 01 1938 | |
| 5. PATIENT'S ADDRESS (No., Street) 123 Hometown Street | | 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY Anytown | STATE NC | 8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | |
| ZIP CODE 27272 | TELEPHONE (Include Area Code) (336) 555-5555 | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: | |

MSP Information

- Provider must make good faith effort to determine whether Medicare is primary or secondary.
 - MSP Questionnaire
 - COB Contractor: 1.800.999.1118
- If the patient has other insurance primary to Medicare, complete:
 - Item 4: Insured's name
 - Item 6: Relationship to insured
 - Item 7: Insured's address
 - Item 8: Patient status
 - Item 10: Employment, auto, or accident indicator
 - Item 11: Insured's policy number

Item 4: Insured's Name

- Enter name of the insured if there is insurance primary to Medicare.
- When insured and patient are the same, enter the word "SAME".

| | | |
|---|-------------------------------|-------------|
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | INFORMATION |
| SAME | | |
| 7. INSURED'S ADDRESS (No., Street) | | |
| SAME | | |
| CITY | STATE | |
| ZIP CODE | TELEPHONE (Include Area Code) | |
| | () | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | | |

- If Medicare is primary, leave Item 4 blank.

Item 6: Patient Relationship to Insured

Check appropriate box for patient's relationship to insured, only when Item 4 is completed.

| | | | |
|---|--|--|--|
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane | | 3. PATIENT'S BIRTH DATE MM DD YY 01 01 1938 M <input checked="" type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) 123 Hometown Street | | 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY Anytown | STATE NC | 8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | |
| ZIP CODE 27272 | TELEPHONE (Include Area Code) (336) 555-5555 | Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: | |

Item 7: Insured's Address

- Enter insured's address and telephone number, only if Items 4 and 6 are completed.
- When address is the same as the patient's, enter "**SAME**".

| | | |
|---|-------------------------------|-------------|
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | INFORMATION |
| SAME | | |
| 7. INSURED'S ADDRESS (No., Street) | | |
| SAME | | |
| CITY | STATE | |
| ZIP CODE | TELEPHONE (Include Area Code) | |
| | () | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | | |

Item 8: Patient Status

Check appropriate box(es) for patient's marital, employment, and student status.

| | | | |
|---|--|--|--|
| <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (COB of ID) (COB) (ID)</small> 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane | | 3. PATIENT'S BIRTH DATE SEX MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 01 01 1938 | |
| 5. PATIENT'S ADDRESS (No., Street) 123 Hometown Street | | 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY Anytown | STATE NC | 8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | |
| ZIP CODE 27272 | TELEPHONE (Include Area Code) (336) 555-5555 | Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: | |

Item 10: Employment, Auto, Accident Indicator

Check each Item, 10a-10c, to indicate whether one of these conditions applies.

| | | | |
|---|-------------------------------|---|---|
| | | Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | |
| ZIP CODE | TELEPHONE (Include Area Code) | Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | ZI |
| | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: | 11 |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (Current or Previous) | a. |
| b. OTHER INSURED'S DATE OF BIRTH | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| MM | DD | YY | SEX |
| | | | M <input type="checkbox"/> F <input type="checkbox"/> |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | b. AUTO ACCIDENT? | b. |
| | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | PLACE (State) |
| | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | c. OTHER ACCIDENT? | c. |
| | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 10d. RESERVED FOR LOCAL USE | d. |

Item 11: Insured's Policy Number

- If there is insurance primary to Medicare, complete Items 11- 11c.
- If Medicare is primary, enter "**NONE**" in Item 11.
- This field cannot be left blank.

| | | |
|---|---|---------------------------------|
| 11. INSURED'S POLICY GROUP OR FECA NUMBER 145368F | | PATIENT AND INSURED INFORMATION |
| a. INSURED'S DATE OF BIRTH MM DD YY 01 01 1938 | SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> | |
| b. EMPLOYER'S NAME OR SCHOOL NAME MAIN STREET GROCERY | | |
| c. INSURANCE PLAN NAME OR PROGRAM NAME BCBS OF NORTH CAROLINA | | |

OR

| | | |
|--|--|---------------------------------|
| 11. INSURED'S POLICY GROUP OR FECA NUMBER NONE | | PATIENT AND INSURED INFORMATION |
| 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 | | |

Medigap Information

- Medigap plans are private health insurance plans that supplement Medicare by filling in some of the “gaps” of Medicare coverage.
- For these plans, crossover is based on the following claim information, only when Medigap insurer did not voluntarily move to COBA *eligibility file-based* crossover:
 - information included in Items 9-9d, and
 - beneficiary authorization in Item 13.
- Refer to: <http://www.cms.hhs.gov/COBAgreement/>
 - Under “Downloads”, find “Medigap Claim-based COBA IDs for Billing Purpose.pdf”
- Crossover for Medigap plans only occurs for participating providers.

Item 9: Medigap Information

- Item 9: Other Insured's Name or "Same" if same as Item 2.
- Item 9a: Medigap policy or group number, preceded by "MG", "Medigap", or "MGAP".
- Item 9b: Medigap insured's DOB and gender.
- Item 9c: Leave blank if COBA ID is entered in 9d.
- Item 9d: Five-digit COBA ID, to be used on claims effective October 1, 2007

| | | | | | |
|--|--|--|--|---|----|
| ZIP CODE | | TELEPHONE (Include Area Code) () | | Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | Zi |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) SAME | | 10. IS PATIENT'S CONDITION RELATED TO: | | 11 | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER MEDIGAP 1234 | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | a. | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY 01 01 1938 | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) | | b. | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | c. | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERVED FOR LOCAL USE | | d. | |

Item 13: Medigap Authorization

- Item 13 must be completed if there is Medigap information in Items 9-9d.
 - Patient signature, or
 - "Signature on File"
- Signature in Item 13 authorizes payment of Medigap benefits to participating provider.

| | | | | | | |
|---|----|----|------------|----|----|----|
| 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 SIGNATURE ON FILE | | | | | | |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | | |
| MM | DD | YY | TO | MM | DD | YY |
| FROM | | | | | | |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | |
| MM | DD | YY | TO | MM | DD | YY |
| FROM | | | | | | |
| 20. OUTSIDE LAB? | | | \$ CHARGES | | | |

Item 10d: Medicaid

- Item 10d is used only for Medicaid information.
- If the patient is entitled to Medicaid, enter patient's Medicaid number preceded by "**MCD**".

10d. RESERVED FOR LOCAL USE
MCD 123456789

Item 12: Beneficiary Signature

- Item 12 is required for all Medicare claims.
- Beneficiary signature authorizes the release of medical information necessary to process the claim.
 - Patient Signature, or
 - **“Signature on File”**

| | | |
|---|---|---|
| <p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> | | |
| <p>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.</p> | | |
| <p>SIGNED SIGNATURE ON FILE</p> | | <p>DATE 01/01/2008</p> |
| <p>14. DATE OF CURRENT: MM DD YY</p> | <p>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)</p> | <p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY</p> |
| <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p> | | |

Now Let's Practice!

Example of Top Half of Form

| | | | |
|---|--|--|--|
| <p>1500</p> <p>HEALTH INSURANCE CLAIM FORM</p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p> | | <p>PICA <input type="checkbox"/></p> <p style="text-align: right;">CARRIER <input type="checkbox"/></p> | |
| <p>1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK (LUNG) <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)</p> | | <p>1a. INSURED'S I.D. NUMBER (For Programs in Item 1)</p> <p>123-45-6789A</p> | |
| <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p>DOE, JANE</p> | | <p>3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/>)</p> <p>01 01 1938 M <input type="checkbox"/> F <input checked="" type="checkbox"/></p> | |
| <p>5. PATIENT'S ADDRESS (No., Street)</p> <p>123 HOMETOWN STREET</p> | | <p>6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>)</p> | |
| <p>CITY ANYTOWN STATE NC</p> | | <p>7. INSURED'S ADDRESS (No., Street)</p> | |
| <p>ZIP CODE 27272 TELEPHONE (Include Area Code) (336) 555-5555</p> | | <p>8. PATIENT STATUS (Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>)</p> | |
| <p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>SAME</p> | | <p>10. IS PATIENT'S CONDITION RELATED TO:</p> | |
| <p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p> <p>MEDIGAP 1234</p> | | <p>a. EMPLOYMENT? (Current or Previous) (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)</p> | |
| <p>b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/>)</p> <p>01 01 1938 M <input type="checkbox"/> F <input checked="" type="checkbox"/></p> | | <p>b. AUTO ACCIDENT? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____)</p> | |
| <p>c. EMPLOYER'S NAME OR SCHOOL NAME</p> | | <p>c. OTHER ACCIDENT? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)</p> | |
| <p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p> <p>55003</p> | | <p>10d. RESERVED FOR LOCAL USE</p> | |
| <p>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.</p> <p>SIGNED SIGNATURE ON FILE DATE 01/01/2008</p> | | <p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p> | |
| <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p> | | <p>a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)</p> | |
| <p>14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, return to and complete item 9 a-d.)</p> | | <p>b. EMPLOYER'S NAME OR SCHOOL NAME</p> | |
| <p>15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, return to and complete item 9 a-d.)</p> | | <p>c. INSURANCE PLAN NAME OR PROGRAM NAME</p> | |

Item 14: Date of Current Illness, Injury, or Pregnancy

Required for all chiropractic claims

- Initiation of treatment plan

| | | |
|---|---|---|
| <p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> | | |
| <p>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.</p> | | |
| <p>SIGNED</p> | <p>SIGNATURE ON FILE</p> | <p>DATE 01/01/2008</p> |
| <p>14. DATE OF CURRENT: MM DD YY 01 01 2008</p> | <p>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)</p> | <p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY</p> |
| <p>16. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p> | | |

Item 15: Date of Same or Similar Illness

Leave blank

- Item 15 is not required by Medicare.

| | | | |
|---|--|--------------------------|---|
| <p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> | | | |
| <p>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.</p> | | | |
| SIGNED | | SIGNATURE ON FILE | DATE 01/01/2008 |
| 14. DATE OF CURRENT: | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE |
| MM DD YY | | | MM DD YY |
| 01 01 2008 | | | |
| 16. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | |

Item 16: Dates Patient Unable to Work

If employed, enter the date range the patient is unable to work due to current condition.

- An entry in this field may indicate employment related insurance coverage.

| | | | | | |
|---|----|----|------------|----|------------|
| 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 SIGNATURE ON FILE | | | | | |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | | | | | |
| FROM | MM | DD | YY | TO | MM DD YY |
| | 01 | 01 | 2008 | | 01 31 2008 |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | |
| FROM | MM | DD | YY | TO | MM DD YY |
| | | | | | |
| 20. OUTSIDE LAB? | | | \$ CHARGES | | |

Item 17: Name/ID of Referring/ Ordering Physician

- Item 17: Name of ordering/ referring physician
- Item 17a: Enter Qualifier “**1G**” & UPIN of ordering/ referring physician
 - UPINs will be allowed to identify ordering/ referring physicians until May 23, 2008.
- Item 17b: Enter NPI of ordering/ referring physician
 - NPIs will be required to identify referring/ ordering physicians effective May 23, 2008.

| | | | | | | |
|--|----------|---------------------|--------|--|----------------|----------------------|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | 17a. 1G | A12345 |
| JOHN SMITH, MD | | | | | 17b. NPI | 1234567890 |
| 19. RESERVED FOR LOCAL USE | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | |
| 1. _____ | | 3. _____ | | | | |
| 2. _____ | | 4. _____ | | | | |
| 24. A. DATE(S) OF SERVICE | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | | E. DIAGNOSIS POINTER |
| From | To | | | MODIFIER | | |
| MM DD YY | MM DD YY | | | | | |

Item 18: Hospitalization Dates Related to Current Services

- Enter hospitalization dates when medical service furnished is a result of, or subsequent to, related hospitalization.

| | | | | | | | |
|---|----|-----------------------------|------|-------------------|----|----|------|
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | |
| | MM | DD | YY | | MM | DD | YY |
| FROM | 01 | 01 | 2008 | TO | 01 | 07 | 2008 |
| 20. OUTSIDE LAB? | | | | \$ CHARGES | | | |
| <input type="checkbox"/> YES | | <input type="checkbox"/> NO | | | | | |
| 22. MEDICAID RESUBMISSION CODE | | | | ORIGINAL REF. NO. | | | |
| 23. PRIOR AUTHORIZATION NUMBER | | | | | | | |

Item 19: Reserved for Local Use

- Independent PT/OT - Date Last Seen and NPI of attending physician
- X-ray date (chiropractor)
- Not Otherwise Classified (NOC) drug - Name and dosage
- NOC code – Narrative description of procedure
- Global surgery
 - split post-operative care
 - assumed and relinquished care dates

| | | | | | | |
|--|----------|------------|--|---------------------|-----------------------|---|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | 17a. 1G A12345 | |
| JOHN SMITH, MD | | | | | 17b. NPI | 1234567890 |
| 19. RESERVED FOR LOCAL USE | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | |
| 1. _____ | | 3. _____ | | | | |
| 2. _____ | | 4. _____ | | | | |
| 24. A. DATE(S) OF SERVICE | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER |
| From | To | | | | | E. DIAGNOSIS POINTER |
| MM DD YY | MM DD YY | YY | | | | |

Item 20: Outside Lab

Complete this item when billing for diagnostic tests.

- Check “yes” or “no” to indicate whether technical portion of test was purchased.
- If “yes”, enter purchase price.

| | | | | | | |
|---|-----|--------------------------|-------------------|-------|----|---------|
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | |
| MM | DD | YY | MM | DD | YY | |
| FROM | 01 | 01 | 2008 | TO | 01 | 07 2008 |
| 20. OUTSIDE LAB? | | | ‡ CHARGES | | | |
| <input checked="" type="checkbox"/> | YES | <input type="checkbox"/> | NO | 20 00 | | |
| 22. MEDICAID RESUBMISSION | | | | | | |
| CODE | | | ORIGINAL REF. NO. | | | |
| 23. PRIOR AUTHORIZATION NUMBER | | | | | | |

Item 21: Diagnosis

- Enter the patient's diagnosis/condition (s).
- All physician and non-physician specialties must use ICD-9-CM codes and code to the highest level of specificity.

| | | | | | | |
|--|----------|---------------------|--------|--|----------------------------|----------------------|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JOHN SMITH, MD | | | | | 17a. 1G A12345 | 1 |
| | | | | | 17b. NPI 1234567890 | |
| 19. RESERVED FOR LOCAL USE | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | |
| 1. 250 01 | | 3. _____ | | | | |
| 2. 401 1 | | 4. _____ | | | | |
| 24. A. DATE(S) OF SERVICE | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | E. DIAGNOSIS POINTER |
| From | To | | | CPT/HCPCS | MODIFIER | |
| MM DD YY | MM DD YY | | | | | |

Item 24e: Diagnosis Pointer

Enter diagnosis code reference number (as shown in Item 21) to relate procedures performed to primary diagnosis for that service.

| | | | | | | |
|--|----|--|--------|---|-----|----------------------|
| 14. DATE OF CURRENT: MM DD YY | | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | | 1 |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | 17a. | | 1 |
| 19. RESERVED FOR LOCAL USE | | | | 17b. | NPI | 2 |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | 2 |
| 1. 250 01 | | 3. _____ | | | | 2 |
| 2. 401 1 | | 4. _____ | | | | 2 |
| 24. A. DATE(S) OF SERVICE From To | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | E. DIAGNOSIS POINTER |
| MM | DD | YY | MM | DD | YY | |
| 01 | 01 | 08 | 01 | 01 | 08 | 11 |
| | | | | 99213 | | 1 |
| 01 | 01 | 08 | 01 | 01 | 08 | 11 |
| | | | | 82947 | | 1 |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Item 22: Medicaid Resubmission Code

Item 22 is not required by Medicare.

- Leave blank.

| | | | | | | | |
|---|-----|--------------------------|------|-------------------|----|----|------|
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | |
| | MM | DD | YY | | MM | DD | YY |
| FROM | 01 | 01 | 2008 | TO | 01 | 07 | 2008 |
| 20. OUTSIDE LAB? | | | | \$ CHARGES | | | |
| <input checked="" type="checkbox"/> | YES | <input type="checkbox"/> | NO | 20 00 | | | |
| 22. MEDICAID RESUBMISSION CODE | | | | ORIGINAL REF. NO. | | | |
| | | | | | | | |
| 23. PRIOR AUTHORIZATION NUMBER | | | | | | | |
| 4345566778 | | | | | | | |

Item 23: Prior Authorization Number

- QIO Authorization Number
- Investigational Device Exemption Number
- HHA Provider Number - 6 digits
- CLIA Number - 10 digits

| | | | | | | | |
|---|-----------|--------------------------|-------------|-------------------|-----------|-----------|-------------|
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | | | | | | | |
| | MM | DD | YY | | MM | DD | YY |
| FROM | 01 | 01 | 2008 | TO | 01 | 07 | 2008 |
| 20. OUTSIDE LAB? | | | | \$ CHARGES | | | |
| <input checked="" type="checkbox"/> | YES | <input type="checkbox"/> | NO | 20 00 | | | |
| 22. MEDICAID RESUBMISSION CODE | | | | ORIGINAL REF. NO. | | | |
| 23. PRIOR AUTHORIZATION NUMBER | | | | | | | |
| 4345566778 | | | | | | | |

Items 24a-24c

- Item 24a: Date of Service
- Item 24b: Place of Service
- Item 24c: EMG
 - Leave blank; not required by Medicare

| | | | | | |
|--|----|---------------------|---|--|----------|
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE | | |
| MM | DD | YY | MM | DD | YY |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | |
| 17a. | | | 17b. NPI | | |
| 19. RESERVED FOR LOCAL USE | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | |
| 1. 250 01 | | 3. | | | |
| 2. 401 1 | | 4. | | | |
| 24. A. DATE(S) OF SERVICE | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | |
| From | To | | | CPT/HCPCS | MODIFIER |
| MM | DD | YY | MM | DD | YY |
| 01 | 01 | 08 | 01 | 01 | 08 |
| 11 | | | | | |
| | | | | 99213 | |
| | | | | 82947 | |
| E. DIAGNOSIS POINTER | | | | | |
| 1 | | | | | |
| 1 | | | | | |

Items 24d-24h

- Item 24d: Procedure codes & modifiers
- Item 24e: Diagnosis pointer
- Item 24f: Line charges
- Item 24g: Number of units
- Item 24h: Leave blank; not required by Medicare

| 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. 250 01 | | | | | | | | | | 3. _____ | | 23. PRIOR AUTHORIZATION NUMBER | | | | |
| 2. 401 1 | | | | | | | | | | 4. _____ | | 4345566778 | | | | |
| 24. A. DATE(S) OF SERVICE | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | E. DIAGNOSIS POINTER | F. \$ CHARGES | | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
| MM | DD | YY | MM | DD | YY | | | CPT/HCPCS | MODIFIER | | | | | | | |
| 01 | 01 | 08 | 01 | 01 | 08 | 11 | | 99213 | | 1 | 75 | 00 | 1 | | NPI | 1234567890 |
| 01 | 01 | 08 | 01 | 01 | 08 | 11 | | 82947 | | 1 | 25 | 00 | 1 | | NPI | 1234567890 |

Items 24i-24j

- Item 24i: ID Qualifier
 - Enter qualifier “**1C**” if you are reporting a PTAN in Item 24j
 - Effective **March 1, 2008**, all claims must contain an NPI as the primary identifier.
 - Effective **May 23, 2008**, no PTAN information will be accepted; will result in claim rejection.
- Item 24j: Rendering Provider ID number

| | | | | | | | | | | | | | | | | |
|--|----|---------------------|--------|--|----|---------|--|----------------------|----------|---|--------------------------------|----|-------------------|----------------------|--------------|-----------------------------|
| 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. 250 01 | | | | | | | | | | | | | | | | |
| 2. 401 1 | | | | | | | | | | | | | | | | |
| 3. _____ | | | | | | | | | | | | | | | | |
| 4. _____ | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE | | | | | | | | | | | F. \$ CHARGES | | G. DAYS OR UNITS | H. ERSOT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
| From | To | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | | E. DIAGNOSIS POINTER | | | | | | | | |
| MM | DD | YY | MM | DD | YY | SERVICE | | CPT/HCPCS | MODIFIER | | | | | | | |
| 01 | 01 | 08 | 01 | 01 | 08 | 11 | | 99213 | | 1 | 75 | 00 | 1 | NPI | 1234567890 | |
| 01 | 01 | 08 | 01 | 01 | 08 | 11 | | 82947 | | 1 | 25 | 00 | 1 | NPI | 1234567890 | |

Item 25: Federal Tax ID Number

Enter the provider's Federal Tax ID Number and check the appropriate box.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 5 | | | | | | | |
| 6 | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | SSN EIN | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small> | |
| 123456789 | | <input type="checkbox"/> <input checked="" type="checkbox"/> | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small> | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | |
| SIGNED | | DATE | | a. NPI | | b. | |
| NUCC Instruction Manual available at: www.nucc.org | | | | | | PLEASE PRINT OR TYPE | |

Item 26: Patient's Account Number

- Item 26 is optional.
- Enter your internal patient account number and it will be returned on your Medicare Remittance Notice.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|----------------------|--|---|
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | SSN EIN | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small> | | 2 | | |
| 123456789 | | <input type="checkbox"/> <input checked="" type="checkbox"/> | | JDOE123 | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small> | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | 3 |
| SIGNED | | DATE | | a. NPI | | b. | | a | | |
| NUCC Instruction Manual available at: www.nucc.org | | | | | | | | PLEASE PRINT OR TYPE | | |

Item 27: Assignment

Check “yes” or “no” as to whether you accept assignment on this claim.

| | | | |
|---|---|---|---|
| 5 | | | |
| 6 | | | |
| 25. FEDERAL TAX I.D. NUMBER 123456789 | SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/> | 26. PATIENT'S ACCOUNT NO. JDOE123 | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" 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.) | | 32. SERVICE FACILITY LOCATION INFORMATION | |
| SIGNED | | a. NPI | b. |
| DATE | | | |
| NUCC Instruction Manual available at: www.nucc.org | | PLEASE PRINT OR TYPE | |

Remember:

- Participating providers must always accept assignment.
- Non-par providers may choose to accept assignment on a claim-by-claim basis.

Items 28- 30

- Item 28: Total Charges
- Item 29: Amount Paid by *Patient* for *Covered Services*
- Item 30: Balance Due
 - Leave blank; not required by Medicare

| | | |
|--|-----------------|-----------------|
| 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. BALANCE DUE |
| \$ 100 00 | \$ 0 00 | \$ |
| 33. BILLING PROVIDER INFO & PH # () | | |
| a. NPI | b. | |
| APPROVED OMB-0938-0999 FORM CMS-1500 (08-05) | | |

Item 31: Provider Signature & Date

Provider or Representative's signature, or "Signature on File", and date

| | |
|---|--|
| <p>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.)</p> <p>SIGNED <i>John Smith, MD</i> DATE 01/01/08</p> | <p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI b.</p> |
| <p>NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE</p> | |

Item 32: Service Facility Location

- Enter name, physical address, and zip code of location where service was rendered.
- Item 32a: NPI of Service Facility
- Item 32b: Qualifier "1C" followed by one space and the PTAN of the Service Facility
 - Effective **March 1, 2008**, all claims must contain an NPI as the primary identifier.
 - Effective **May 23, 2008**, no PTAN information will be accepted; will result in claim rejection.

| | | |
|---|--|----------------------|
| 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 ABC Medical Clinic 123 Medical Park Drive Anywhere, NC 27272 | |
| SIGNED <i>John Smith, MD</i> DATE 01/01/08 | a. NPI | b. |
| NUCC Instruction Manual available at: www.nucc.org | | PLEASE PRINT OR TYPE |

Item 33: Provider Billing Information

- Enter billing name, address, zip code, and telephone number.
- Item 33a: NPI of Billing Provider or Group
- Item 33b: Qualifier “**1C**” followed by one space and the PTAN of the Billing Provider or Group
 - Effective **March 1, 2008**, all claims must contain an NPI as the primary identifier.
 - Effective **May 23, 2008**, no PTAN information will be accepted; will result in claim rejection.

| | | | | | |
|---|--|----|----|----|--|
| \$ | | \$ | | \$ | |
| 33. BILLING PROVIDER INFO & PH # (336) 555-5555 | | | | | |
| ABC Medical Clinic | | | | | |
| 123 Medical Park Drive | | | | | |
| Anywhere, NC 27272 | | | | | |
| a. 1234567890 | | | b. | | |
| APPROVED OMB-0938-0999 FORM CMS-1500 (08-05) | | | | | |

Time to Practice!

Example of Bottom Half of Form

| | | | | | |
|---|----------------------|--|---|--|--------------------------------|
| 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 | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JOHN DOE, MD | | | 17a. | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 19. RESERVED FOR LOCAL USE | | | 17b. 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. 250 01 2. 401 1 | | | 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 EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | E. DIAGNOSIS POINTER |
| F. \$ CHARGES | | G. DAYS OR UNITS | H. EPOBT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
| 1 | 01 01 08 01 02 08 11 | | 99213 | | 1 |
| 2 | 01 01 08 01 01 08 11 | | 82947 | | 1, 2, 3 |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" 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.) <i>John Smith, MD</i> DATE 01/01/08 | | 32. SERVICE FACILITY LOCATION INFORMATION ABC MEDICAL CLINIC PO BOX 123 ANYWHERE, NC 27272 | | 29. TOTAL CHARGE \$ 100 00 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$ 100 00 | |
| | | 33. BILLING PROVIDER INFO & PH # ABC MEDICAL CLINIC PO BOX 123 ANYWHERE, NC 27272 | | (336) 555-5555 | |
| SIGNED <i>John Smith, MD</i> DATE 01/01/08 | | a. NPI | | b. 1234567899 | |

PHYSICIAN OR SUPPLIER INFORMATION

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

The Claims Crossover Process

Crossover

- Coordination of Benefits Contractor (COBC) completes the crossover process.
 - Medicare processes claim.
 - Claim is posted to Common Working File.
 - File is sent to COBC.
 - COBC forwards crossover info to Supplemental Insurer.
- There are three types of Crossover:
 - Complementary
 - Medicaid
 - Medigap

Complementary Crossover

- Trading partners supply eligibility information.
- No additional information is needed on the claim for crossover to occur.
- Crossover occurs for both assigned & nonassigned claims.
- “MA18” on Remittance Advice indicates crossover occurred.

Medicaid Crossover

- Similar to complementary crossover
- Mandatory assignment for dual-eligibles
- Eligibility file received from State Medicaid Agency
- **Item 10d** must be completed on the CMS-1500 form for Medicaid Crossover to occur.
- **“MA07”** on Remittance Advice indicates crossover to Medicaid occurred.

Medigap Crossover

- Private health insurance plans that supplement Medicare
 - Fill in some of the “gaps” in Medicare coverage
- Crossover based on information submitted on claim, only when Medigap insurer did not voluntarily move to COBA *eligibility file-based* crossover
 - The word “Medigap” or an abbreviation (MG or MGAP) in **Item 9a**
 - COBA ID in **Item 9d**
 - Beneficiary authorization in **Item 13**

Medigap Crossover

- Refer to:
<http://www.cms.hhs.gov/COBAgreement/>
 - Under “Downloads”, find “Medigap Claim-based COBA IDs for Billing Purpose.pdf”
- Must be participating physician/supplier
- **“MA18”** on Remittance Advice indicates crossover occurred.

Medicare Remittance Advice

Remittance Advice (RA)

- RAs are standardized payment reports issued to Medicare providers to explain payment and adjustments of Medicare-processed claims.
- Remittance Advices may be:
 - Electronic (ERA), or
 - Paper (SPR)
- Medicare Remit Easy Print (MREP) Software is available free of charge to assist providers in viewing and printing ERAs in the SPR format.

Section One: Provider Information

Section One contains information such as:

- Provider mailing address and identification information
- Number of pages in RA
- Check Number/ EFT Number

CIGNA GOVERNMENT SERVICES
P. O. BOX 1465
NASHVILLE, TN 37202
1.866.502.9056

MEDICARE
REMITTANCE
NOTICE

WELLMAN GROUP PRACTICE
200 DOCTORS DRIVE
SUITE 200
SOMEWHERE, TN 37200-0200

PROVIDER #: 3700000
PAGE #: 1 OF 2
DATE: 12/18/2006
CHECK/EFT #:
00002421100

NPI Alert 10.2.06-5.22.07: Medicare recommends all those billing Medicare to continue submitting the Medicare legacy identifier as a secondary identifier. If there is any issue with the provider's NPI and no Medicare legacy is submitted, the provider may not be paid.

Section Two: Claim Level Information

Section Two provides claim level information such as:

- Patient information
- Services billed & how items were processed
- Individual claim totals

| <u>PERF</u> | <u>PROV</u> | <u>SERV DATE</u> | <u>POS</u> | <u>NOS</u> | <u>PROC</u> | <u>MODS</u> | <u>BILLED</u> | <u>ALLOWED</u> | <u>DEDUCT</u> | <u>COINS</u> | <u>GRP/RC-AMT</u> | <u>PROV PD</u> | |
|----------------|----------------|------------------|------------|------------|--------------|-------------|---------------|--------------------|---------------|--------------|-------------------|----------------|-------|
| NAME | CRATER, JOSEPH | | HIC | 410000001A | ACNT | CRAT001 | ICN | 0207035568420 | ASG | Y | MOA | MA07 | |
| 3000001 | 0115 | 011507 | 11 | 1 | 99213 | | 85.00 | 55.87 | 35.05 | 4.16 | CO-42 | 29.13 | 16.66 |
| 3000001 | 0115 | 011507 | 11 | 1 | 36415 | | 10.00 | 3.00 | 0.00 | 0.00 | CO-42 | 7.00 | 3.00 |
| PT RESP | 39.21 | | | | CLAIM TOTALS | | 95.00 | 58.87 | 35.05 | 4.16 | | 36.13 | 19.66 |
| ADJ TO TOTALS: | PREV PD | 0.00 | | | INTEREST | 0.00 | | LATE FILING CHARGE | | | 0.00 | NET | 19.66 |

Section Three: Total Remittance Information

Section Three contains RA total information such as:

- Claims reported on RA
- Billed amount
- Allowed amount
- Deductible applied
- Coinsurance amount
- Provider paid amount
- Amount of check

| TOTALS: | # OF CLAIMS | BILLED AMT | ALLOWED AMT | DEDUCT AMT | COIN AMT | TOTAL RC-AMT | PROV PD AMT | PROV ADJ AMT | CHECK AMT |
|---------|----------------|---------------|----------------|---------------|-------------|-----------------|----------------|-----------------|--------------|
| | 1 | 95.00 | 58.87 | 35.05 | 4.16 | 36.13 | 19.66 | 0.00 | 19.66 |

Section Four: Glossary

Section Four of the RA contains descriptors for:

- Group codes
 - Identify financial responsibility
- Reason codes
 - Used in combination with group codes
- Remark codes
 - Provide specific remarks for line items
- MOA codes
 - Contain information for entire claim

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Code

| | |
|----|---|
| BF | Balance Forward |
| CO | Contractual Obligation. The amount for which the provider is financially liable. The patient may not be billed for this amount. |
| CR | Correction/Reversal of a previously adjudicated service/claim. |
| IN | Interest. |
| OA | Other Adjustment. |
| PR | Patient Responsibility. The amount that may be billed to a patient or another payer. |

Reason Codes:

CO-42 Charges exceed our fee schedule or maximum allowable amount.

Remark Codes:

MOA Codes:

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

Module Review

- **Review Question 1:**
What is the length of time a provider has in which to submit a claim to Medicare?
- **Review Question 2:**
Which item of the CMS-1500 form would you populate with service facility location information?
- **Review Question 3:**
What is the difference between Medigap and complementary crossover?

Questions
