Completing a CMS 1500 Form

Coordinated Care only accepts the CMS 1500 (02/12) and CMS UB-04 original red paper claim forms. Copies, handwritten claims, and other claim form types will be rejected.

- Effective April 1, 2013 any UB-04 and CMS-1500 forms received that do not meet the CMS printing requirements will be rejected back to the provider or facility upon receipt.
- The only acceptable claim forms are those printed in Flint OCR Red, J6983, or exact match ink. Although a copy of the CMS-1500 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. The majority of paper claims sent to carriers and DMERCs are scanned using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted by all carriers and DMERCs.

The National Uniform Billing Committee (NUBC) is responsible for the design of the form, and award of the contract for printing of the form. CMS does not supply the form to providers for claim submission. Blank copies of the form may also be available through office supply stores in your geographic area.

Submit first time claims to Coordinated Care at the following address:

Coordinated Care
Claim Processing Department
P. O. Box 4030
Farmington, MO 63640-4197

- ***Coordinated Care cannot receive claims at our Tacoma, WA address and will return them to the provider.***

Coordinated Care encourages all providers to submit claims securely on the web portal or electronically. Paper submissions are subject to the same edits as electronic and web submissions. Refer to our Companion Guides at www.CoordinatedCareHealth.com.

Coordinated Care will only accept the 02/12 version of the CMS 1500 (HCFA). Approved forms will say "Approved OMB-0938-1197 FORM 1500 (02-12)" on the bottom right hand corner. Refer to the NUCC website for further detailed instructions. Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. **Note: Claims with missing or invalid Required (R) field information will be rejected or denied.**

Field		Field Description	Instruction or Comments
1	R	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. Enter “X” in the box noted “Other”
1a	R	INSURED’S ID NUMBER	The 11-digit Medicaid ID number on the member’s Coordinated Care ID card.
2	R	PATIENT’S NAME (Last Name, First Name, Middle Initial)	Enter the patient’s name as it appears on the member’s Coordinated Care ID card. Do not use nicknames.
3	R	PATIENT’S BIRTH DATE/SEX	Enter the patient’s 8-digit date of birth (MMDDYYYY). Mark the appropriate box to indicate if the patient is male (M) or female (F).
4	C	INSURED’S NAME	Enter the patient subscriber’s name.
5	 C	PATIENT’S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient’s Telephone does not exist in the electronic 837 Professional 4010A1.
6	C	PATIENT’S RELATION TO INSURED	Always mark to indicate self.
7	C	INSURED’S ADDRESS (Number, Street, City, State, Zip Code)	Enter the patient's complete address and telephone number including area code on the appropriate line.

	Telephone (include area code)	First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.
9 C	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.
9a C	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.
9b C	OTHER INSURED'S BIRTH DATE/SEX	REQUIRED if field 9 is completed. Enter the 8 digit date of birth (MMDDYYYY) and mark the appropriate box to indicate the sex/gender for the person listed in field 9. M = male F = female
9c C	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in field 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.
9d C	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (person listed in field 9) insurance plan or program name.
10a,b,c R	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.
10d	RESERVED FOR LOCAL USE	Always mark to indicate self.
11 C	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.
11a C	INSURED'S DATE OF BIRTH / SEX	Same as field 3.
11b C	EMPLOYER'S NAME OR SCHOOL NAME	REQUIRED if Employment is marked Yes in Field 10a.
11c C	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.
11d R	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.

12 C	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.
13	PATIENT'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.
14 C	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6 digit (MMDDYY) or 8 digit (MMDDYYYY) onset for the: Present illness Injury LMP (last menstrual period) if pregnant
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	If applicable, enter the date in the following format: MMDDYYYY. Do not include hyphens, dashes, etc.
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	If applicable, enter the date in the following format: MMDDYYYY. Do not include hyphens, dashes, etc.
17a,b C	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials). REQUIRED for PRC Lock-In members. Field a – ID Number: Use ZZ qualifier for Taxonomy code. Field b – NPI Number REQUIRED for PRC Lock-In members.
18 C	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	REQUIRED for professional services related to a continuous inpatient stay. If applicable, enter the date in the following format: MMDDYYYY. Do not include hyphens, dashes, etc.
19	ADDITIONAL CLAIM INFORMATION	Enter any notes that would help in processing a claim for payment.
20	OUTSIDE LAB / CHARGES	If applicable, check the appropriate box and enter charges.

21 R	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD- 9/ICD-10 CM Volume 1 for the date of service. Diagnosis codes submitted must be valid ICD- 9/ICD-10 codes for the date of service and carried out to its highest digit – 4th or 5th. 'E' codes are NOT acceptable as a primary diagnosis. New form requires ICD indicator: 9 – ICD-9-CM 0 – ICD-10-CM
22 C	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the DCN (Document Control Number) of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim
23 C	PRIOR AUTHORIZATION NUMBER	Enter the authorization number if a prior auth was acquired.
24a-g Shaded C	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Anesthesia start/stop time & duration Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. HIBCC or GTIN number/code. For detailed instructions and qualifiers, refer to the Billing Tips and Reminders section of this guide.
24d Unshaded R	PROCEDURES, SERVICES OR SUPPLIES	Enter the 5-digit CPT or HCPCS code and 2- character modifier, if applicable.
	CPT/HCPCS MODIFIER	Only one CPT or HCPCS and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.
24e Unshaded R	DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1, 2, 3, and 4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service or the claim will be rejected/denied.

24f Unshaded R	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.
24g Unshaded R	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.
24h Shaded C	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.
24h Unshaded C	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.
24i Shaded R	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use or 1D qualifier for ID, if an Atypical Provider.
24j Shaded R	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24i shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.
24j Unshaded R	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10- character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, etc.).
25 R	FEDERAL TAX ID NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.
26 C	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.
27 C	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Coordinated Care recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.
28 R	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24f. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.

29 C	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Coordinated Care. Coordinated Care is always the payer of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters
30 C	BALANCE DUE	Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.
31 R	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. **Note:** Does not exist in the electronic 837P.
32 C	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.
32a C	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the clinic/facility where services were rendered.

32b C	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).
33 R	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.
33a R	GROUP BILLING NPI	Enter the 10-character NPI ID.
33b R	GROUP BILLING OTHERS ID	Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For gov. claims, see back. YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)