# CMS-1500 02/12

## 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 G UMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. IN DATE DD SEX F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (St YES NO

OTHER (Desig C)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

NCE ME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES NUC

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

READ BACK OF FORM BEFORE COMPLETING & SIGN

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the r er info cessa to process this claim. I also request payment of government benefits either t o the p ccepta ment below.

SIGNED

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize yment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS MM DD YY or PREG (LM ER MM DD YY

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

17. NAME OF REFERR OVIDER OR OTHER SOU 17b. NPI

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

19. ADDITIONAL CLAIM y NU

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE URY 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

| 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 govt. 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.

## CMS-1500 (02/12)

Please note the following:

- Using the 02/12 version with the 08/05 format does not work. The diagnosis codes for Box 21 end up in the wrong location, and the Claims Unit will not key them to fit.
- If claims do not follow the 02/12 format, payment of your claims could be affected. Work with your software vendor to fix this issue.

In conjunction with the incorrect claim format, boxes for diagnosis code pointers are being completed incorrectly:

- 24E is alphabetic, not numeric.
- We currently accept diagnosis codes in Boxes A–D on the CMS-1500 (02/12); for the 837P X12 5010 electronic claim this equate to 1–4. Anything submitted in boxes other than A–D on the CMS‑1500 (02/12) or other than 1–4 on the 837P X12 5010 electronic claim could cause denial of line or claim.
- **Box 10d Claim Codes**
  - No longer scanned for the member ID. Montana Medicaid scans 1a, 9a, and 11 for the member ID.
- **Box 17 Name of Referring Provider or Other Source**
  - Montana Medicaid accepts with referring provider's name.
- **Box 17a Unlabeled Field**
  - Montana Medicaid reserves for Passport to Health referral number.
- **Box 17b NPI and Unlabeled Field**
  - Montana Medicaid reserves for Indian Health Services referral number.
- **Box 21 Diagnosis or Nature of Illness or Injury**
  - Decimal points are not allowed in Boxes A–L for diagnosis pointer.
- **Box 29 Amount Paid**
  - Montana Medicaid reserves for third party liability payments.

Providers rebilling a claim after April 1 must use the 02/12 version even if the 08/05 version was used to bill the claim.

Although a sample CMS-1500 (02/12) is on the Forms page of the Montana Medicaid Provider Information website, http://medicaidprovider.hhs.mt.gov, claim forms must be ordered from an authorized vendor.

For more information, see the instruction manual on the NUCC website:
http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02.pdf