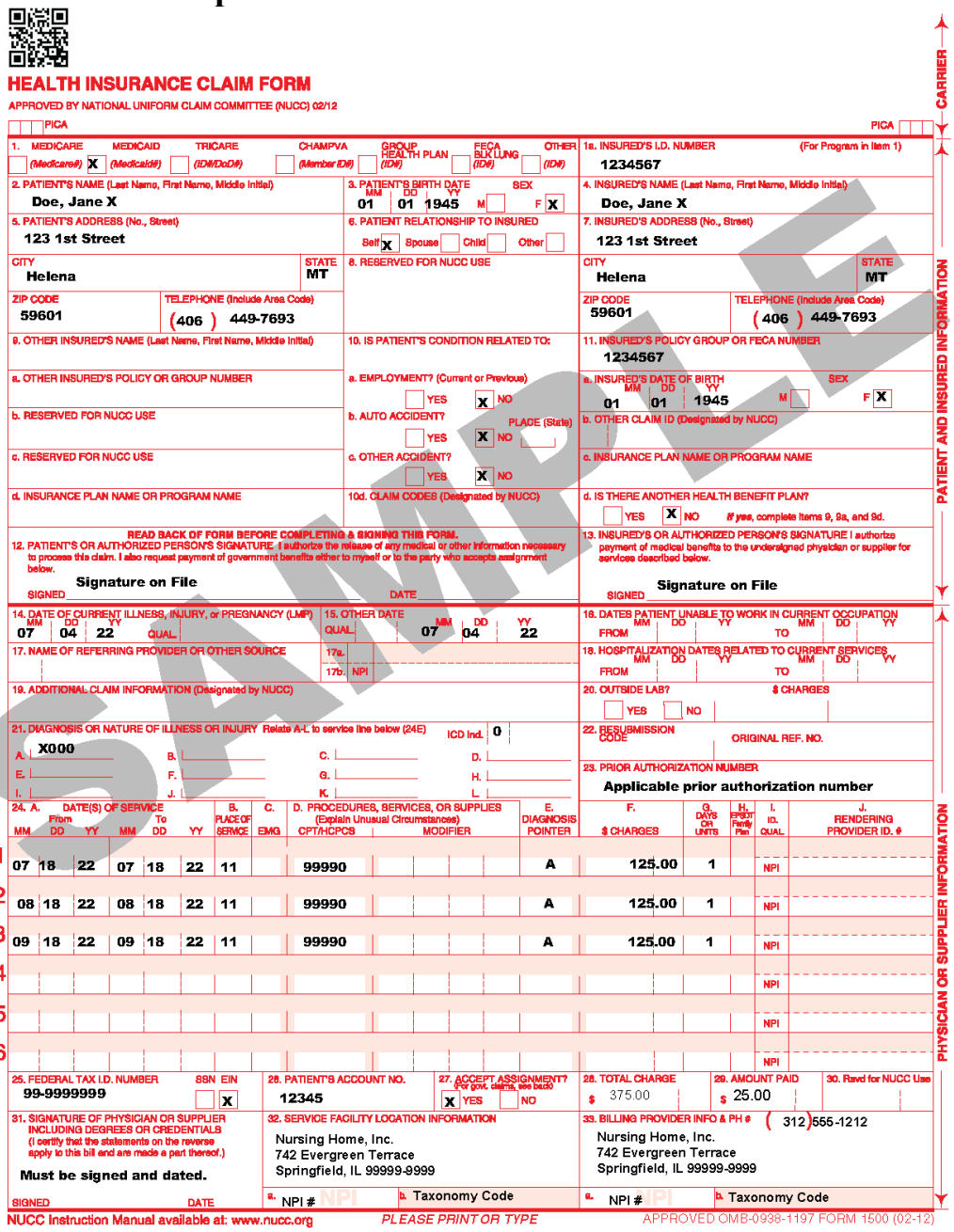
MONTANA HEALTHCARE PROGRAMS NOTICE
December 12, 2022

Nursing Facility Providers

CMS-1500 Claims Processing for Nursing Facility Providers

The CMS-1500 is used by Nursing Facilities to bill ancillary and other miscellaneous charges that are **not** part of the all-inclusive rate billed on the UB-04 (e.g., COVID vaccinations, tests, and Add-Ons). To assist Nursing Facility billing staff in completing the CMS-1500 claim form, instructions and a sample are provided.

CMS-1500 Claim Form Sample



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [X] MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER: 1234567 (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane X

3. PATIENT'S BIRTH DATE: 01 01 1945 SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane X

5. PATIENT'S ADDRESS (No., Street): 123 1st Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 123 1st Street

CITY: Helena STATE: MT

8. RESERVED FOR NUCC USE

CITY: Helena STATE: MT

ZIP CODE: 59601 TELEPHONE (Include Area Code): (406) 449-7693

ZIP CODE: 59601 TELEPHONE (Include Area Code): (406) 449-7693

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: 1234567

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH: 01 01 1945 SEX: M F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [X] 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 [X] 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: Signature on File 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: Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 07 04 22 QUAL

15. OTHER DATE QUAL 07 04 22

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. 0

A. X000 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: Applicable 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 07 18 22	07 18 22	11		99990		A	125.00	1		NPI	
2 08 18 22	08 18 22	11		99990		A	125.00	1		NPI	
3 09 18 22	09 18 22	11		99990		A	125.00	1		NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 375.00

29. AMOUNT PAID: $ 25.00

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.)

Must be signed and dated.

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Nursing Home, Inc.
742 Evergreen Terrace
Springfield, IL 99999-9999

a. NPI # b. Taxonomy Code

33. BILLING PROVIDER INFO & PH #: (312)555-1212

Nursing Home, Inc.
742 Evergreen Terrace
Springfield, IL 99999-9999

a. NPI # b. Taxonomy Code

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CMS-1500 Claim Form Information

Although a sample CMS-1500 claim form is on the Montana Healthcare Programs Provider Information website, claim forms must be ordered from an authorized vendor. 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 have sometimes been completed incorrectly. Please review the content below for additional guidance.

- **Box 10d Claim Codes**
  - No longer scanned for the member ID. Boxes 1a, 9a, and 11 are scanned for the member ID.
- **Box 17 Name of Referring Provider or Other Source**
  - Accepted with referring provider's name.
- **Box 17a Unlabeled Field**
  - Field reserved for Passport to Health referral number.
- **Box 17b NPI and Unlabeled Field**
  - Reserved for Indian Health Service referral number.
- **Box 21 Diagnosis or Nature of Illness or Injury**
  - Decimal points are not allowed in Boxes A-L for diagnosis codes.
- **Box 23 Prior Authorization**
  - Required for Add-Ons or any other prior authorization required claim.
- **Box 24b Place of Service**
  - Required.
- **Box 24e Diagnosis Pointer**
  - Required. This field is alphabetic, not numeric. It is related to Box 21 Diagnosis or Nature of Illness or Injury, which is for the diagnosis code.
- **Box 24F and G Charges and Days or Units**
  - Reserved for claims charges for the number of days and/or units that are being requested. Charges must match the number of days/units per the dates of service and allowed charges per any authorization.
- **Box 29 Amount Paid**
  - Reserved for third party liability payments, excluding Medicare.
- **Box 31 Signature of Physician or Supplier**
  - Claim must have a signature and a date, or it will be denied.
- **Box 33b Unlabeled Field**
  - Reserved for Taxonomy code.

Contact and Website Information

For other claims questions or Add-On questions, please call or email Jenifer Thompson, Facility Based Claims Specialist, at (406) 444-3997 or Jenifer.Thompson@mt.gov.

For claims questions or additional information, contact Montana Provider Relations at (800) 624-3958 or (406) 442-1837 or email Montana Provider Relations Helpdesk.

Visit the Montana Healthcare Programs Provider Information website to access your provider type page. Choose Resources by Provider Type in the left-hand menu.