

CMS-1500 (02-12)

Health Insurance Claim Form

Physician and Non-Physician, Professional Services, Laboratory, Independent Diagnostic Testing Facilities (IDTF), Ambulance and other Transportation, EPSDT Service, Ambulatory Surgical Center, Family Planning, Behavioral Health Service, Vision, Therapists (Speech, Physical and Occupational), Health Department, and Durable Medical Equipment Supplier must bill on the CMS-1500.

- ***Atypical providers are providers who are not eligible for a National Provider Identifier (NPI) under HIPAA and the rules of the National Plan and Provider Enumeration System (NPPES). These providers therefore are exempt from billing with an NPI and must use a Medicaid-assigned provider identification number. All HIPAA-covered entities, whether individuals or organizations, are required to obtain and bill with an NPI.***
- ***ID/DD Waiver and Behavioral Health Clinic/Rehabilitation providers must bill only one procedure code and the corresponding prior authorization number on each claim. Multiple (different) procedure codes requiring different authorization numbers cannot be submitted on the same claim form.***

Table of WV Medicaid Required Fields, Comments, Etc.

Required Field Indicators:
 Blank = Not Required
 C = Conditionally Required
 R = Required Field

****Note – All requirements will be enforced on January 1, 2015. Failure to comply could result in claim rejections.**

Form Locator	Required Field	Field Name	Comments
1a	R	Insured's ID Number	Enter the 11 (eleven)-digit Medicaid member ID (MAID) or the 10 (ten)-digit CHIP PIN number for member.
2	R	Patient's Name	Enter name of the patient. Last Name, First Name and Middle Initial. Include any suffix (Jr., Sr.).
3	R	Patient's Birth date and Sex	Enter the valid date of birth. Format = MMDDCCYY or MMDDYY. Check the correct box for patient sex. Male (M) Female (F)
4		Insured's Name	No entry required.

Form Locator	Required Field	Field Name	Comments
5	R	Patient's Address	Enter the patient's full address. Street Address, City, State and 9-digit ZIP code.
6		Patient's Relationship to the Insured	No entry required.
7		Insured's Address	No entry required.
8		Reserved for NUCC Use	No entry required.
9	C	Other Insured's Name	Enter the policyholder's name of Insurance other than Medicaid that covers this patient - If no other insurance, skip to Form locator 10.
9a	C	Other Insured's Policy or Group Number	Enter policy or group number of the Insurance.
9b		Reserved for NUCC Use	No entry required.
9c		Reserved for NUCC Use	No entry required.
9d	C	Insurance Plan Name or Program Name	Enter the plan name of insurance other than Medicaid.
10		Is Patient's Condition related to:	If condition is related to box 10a, 10b, or 10c then a date is required in box 14
10a	C	Employment?	Indicate yes or no with an "X" if the Patient's condition is related to employment; if yes, then a date is required in box 14.
10b	C	Auto Accident?	Indicate yes or no with an "X" if the Patient's condition is related to an auto accident. If yes, enter the 2-digit state abbreviation of the state where the auto accident occurred and a date is required in box 14.
10c	C	Other Accident?	Indicate yes or no with an "X" if the Patient's condition is related to an accident other than an auto accident. If yes, a date is required in box 14.
10d		Claim codes (Designated by NUCC)	
11		Insured's Group Number	No entry required.
12		Patient's Signature	No entry required.
13		Insured's Signature	No entry required.

Form Locator	Required Field	Field Name	Comments
14	C	Date of Current Illness, Injury and/or Pregnancy	Enter valid date of current accident (auto or other). Format = MMDDCCYY or MMDDYY **Required if box 10b Auto Accident&/or box 10c Other Accident is marked Yes. Enter valid date of Current Onset of Illness if not related to "cause check" in 10a, b or c. Format = MMDDCCYY or MMDDYY
15		Other Date	No entry required.
16		Dates Patient Unable to Work	No entry required.
17	C	Name of Referring Physician or Other Source	Enter Last Name and First Name of Referring Physician or other source.
17a	C	Referring Physician's Identification Number	NPI is required unless provider is not eligible per NPPES and uses Atypical Provider Identification (API). Enter G2 in the first box followed by the referring physician's 10-digit NPI (or API, if applicable) - Leave blank if patient was not referred. Leave blank if NPI is entered in 17b.
17b	C	Referring Physicians NPI	Enter the 10-digit NPI of the referring physician.
18		Hospitalization Dates	No entry required.
19	C	Reserved for Local Use:	No entry required.
20		Outside Lab	No entry required.

Form Locator	Required Field	Field Name	Comments
21	R	ICD Indicator	Enter 0 for ICD-10. Note: This is a 1-digit field.
21A-L	R	Diagnosis code	Enter diagnosis codes in priority order (primary, secondary, etc.). Diagnosis code 'A' is required.
22	C	Resubmission Code / Original Reference Number	Medicaid Resubmission code: Valid values = 1, 7 or 8. 1= Initial Claim 7= Prior claim/Replacement 8= Cancellation of Prior Claim **Requires 'Original Reference (Claim) Number' if Resubmission code = '7' or '8'. This is the Medicaid or CHIP original claim ID.
23	C	Prior Authorization Number	Enter the prior authorization number, if applicable for the claim - The claim must be split if more than one prior authorization number applies.
24	R	Service Lines	**At least one service line is required. Maximum of 6 lines per claim.

Form Locator	Required Field	Field Name	Comments
24a	R or C	NDC number-Shaded area (required when billing CPT/HCPCS codes for a drug)	<p>Shaded area: Drug codes require NDC. See www.dhhr.wv.org/bms.com for the Drug Code List for procedure codes that require NDC codes and additional NDC billing instructions/FAQs. Enter the NDC qualifier of N4, followed by an 11-digit NDC number.</p> <ul style="list-style-type: none"> Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC number. The NDC number submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.
	R	Dates of Service-Unshaded area	<p>Unshaded area: Enter the From and To date(s) the service was provided, using the following format MMDDYY</p> <p>.</p> <p>“From Date” must be greater or equal to the “To Date”.</p>
24b	R	Place of Service - (unshaded area)	<p>Enter the appropriate 2-digit code for place of service. Refer to CMS for the most current POS table: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html</p>
24c	C	EMG – unshaded area	If emergency, then enter ‘Y’ for Yes.

Form Locator	Required Field	Field Name	Comments
24d	C R	NDC unit measurement-Shaded area Procedure Code- Unshaded area	<p><u>Shaded area:</u> Enter the NDC unit of measurement and numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal point and three numbers may follow the decimal. The unit of measurement codes are: F2 -International Unit GR-Gram ML-Milliliter UN- Unit Refer to www.dhhr.wv.gov/bms.com for additional NDC billing instructions/FAQ's</p> <p><u>Unshaded area:</u> Enter the 5-digit CPT or HCPCS procedure code that describes the procedure performed. If service provided requires modifier(s), enter up to four modifiers in the column(s) provided following the CPT or HCPCS code.</p>
24e	R	Diagnosis Pointer –unshaded area	<p>Enter the letters from block 21 that identify the diagnosis codes. Applicable to the procedure billed on the line.</p> <p>The reference letters A - H are required. Note: I – L are not allowed at this time.</p>
24f	R	Charges	<p>Enter the total charge for the procedure performed.</p> <p>**Note** If no decimal point is present, the amount left of the divider on claim form will be captured as whole dollars and the amount to the right of divider as cents.</p>

Form Locator	Required Field	Field Name	Comments
24g	R	Unit(s)	<p>Enter the quantity or number of units of the service provided.</p> <p>CPT "0" codes: Bill 15 minute time units for DOS prior to 7/1/2017; bill minutes for DOS 7/1/2017 and after for paper claims only (Do Not bill base units).</p>
24h	C	EPSDT/Family Planning (For providers participating in EPSDT and Family Planning programs only)	<p>WV Medicaid valid values include: Y = EPSDT N = Non-EPSDT</p>
24i	C	ID Qualifier – Shaded Area	<p>Enter PXC when entering the taxonomy code for the servicing provider in block 24j. Or, enter G2 as a qualifier for legacy Medicaid ID. If the rendering provider is a One to Many provider (one NPI to more than one Medicaid legacy number), enter the provider's taxonomy code in 24j along with the qualifier PXC in block 24i <i>if applicable</i>.</p>
24j	C	<p>Rendering provider's Legacy Medicaid ID – Shaded area</p> <p>Rendering provider's NPI - Unshaded area</p>	<p>NPI is required unless provider is not eligible per NPPES and uses Atypical Provider Identification (API).</p> <p><u>Shaded area:</u> Enter the atypical provider's 10-digit Medicaid provider number if no NPI is provided.</p> <p><u>Unshaded area:</u> Enter the rendering provider's NPI number on each line billed.</p> <p>Entry is <u>required</u> if the provider is a physician, APRN, therapist, etc.; <u>a person</u> and the payment/remit is going to a group or "pay-to" location documented in block 33.</p>

Form Locator	Required Field	Field Name	Comments
25	R	Fed Tax ID	Indicate whether the Federal tax ID# is SSN or EIN. Enter Federal Tax ID#. Must be 9 numeric characters.
26	R	Patient's Account Number	Enter patient's account number or name. Alphanumeric characters may be used (maximum of 20). The account number or name will be printed on the WV Medicaid remittance advice.
27		Accepts Assignment	No entry required.
28	R	Total Charge	Enter total charges. Note: For multiple page claims, enter total charges on the last page only. Multiple page claims must specify page (1 of 2, 2 of 3, etc.) on the top of the claim.
29	C	Amount Paid	Attach Medicare and/or TPL EOBs to claim form. Write " Medicare HMO " on the paper EOB from Medicare HMOs. TPL and Medicare HMOs denials <i>must</i> be billed on paper with the EOB showing denial codes <u>and</u> the descriptions. (Services approved by TPL and Medicare HMOs may be billed electronically.) Bill denied and approved claim lines on separate claims. Note: Medicare (not Medicare HMO) denied claims or claim lines on paid claims, may be billed electronically with the Medicare Action Codes.
30		Balance Due	No entry required.
31	R	Signature and Date	Signature of person authorized to certify this claim. By signing the BMS Provider Enrollment Agreement providers have certified that all information listed on a claim for reimbursement by Medicaid is true, accurate and complete. Therefore, claims may be endorsed with a computer-generated, manual or stamped signature. Enter the claim submission date.

Form Locator	Required Field	Field Name	Comments
32	C	Service Facility Location Information	Enter Facility Name, address, city, state and 9-digit ZIP code. **Required if 32A contains Service Facility Location NPI.
32a & b	C	Servicing Facility NPI Servicing Facility Taxonomy	Enter Service Facility if needed in the following format. Provider 10-digit NPI, dash, 3 digit facility code. OR Provider 10-digit Medicaid ID, dash, 3-digit facility code (service location identifier). Example: 0123456789-123 (no spaces).
33	R	Billing Provider Info and Phone number	Enter required billing provider information as followed: Phone Name Street Address City, State & 9-digit ZIP code
33a	R	NPI number of Physician, Group, or Supplier	Enter the NPI of the billing provider, group or pay-to. If there is a servicing/rendering in 24j then enter the pay to or group NPI number in 33a.
33b	C	Taxonomy code of Physician, Group, Supplier, or Pay To	Enter PXC (qualifier) if you are entering in a taxonomy code for the provider in 33A. (No spaces between qualifier and value.) *For Atypical providers, enter qualifier G2 followed by the Medicaid legacy ID number.