CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1058 **Date: SEPTEMBER 15, 2006**

CHANGE REQUEST 5060

Transmittal 1010, CR 5060 dated July 28, 2006, is being rescinded and replaced by Transmittal 1058, CR 5060. In Section B. Policy, Code N271 incorrectly stated "primary identifier" and should be "secondary identifier". All other information remains the same.

SUBJECT: Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (08/05)

I. SUMMARY OF CHANGES: This Change Request (CR) follows up on CR 4293, Transmittal 899 that provided contractor guidance for implementing the revised Form CMS-1500 (08-05). This CR provides additional business requirements directed to Carriers, DMERCs, MCS, and VMS related to validation edits.

In addition, the implementation timelines outlined in CR 4293 for the revised Form CMS-1500 (08/05) were changed and therefore require modification in Pub. 100-04, Medicare Claims Processing Manual, Chapter 26. In addition to the timeline changes, there are minor corrections to the Form CMS-1500 (08/05) print file specifications (Exhibit 2) and to the language in various Item numbers in section 10.4.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2007
IMPLEMENTATION DATE: January 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/Table of Contents
R	26/10/Health Insurance Claim Form CMS-1500
R	26/10/10.4/Items 14-33 – Provider of Service or Supplier Information
R	26/30/Exhibit 2, Form CMS-1500 (08/05) User Print File Specifications

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1058	Date: September 15, 2006	Change Request 5060

Transmittal 1010, CR 5060 dated July 28, 2006, is being rescinded and replaced by Transmittal 1058, CR 5060. In Section B. Policy, Code N271 incorrectly stated "primary identifier" and should be "secondary identifier". All other information remains the same.

SUBJECT: Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (08/05)

I. GENERAL INFORMATION

Shared system changes are required in order to receive and process the revised Form CMS-1500 (08-05). The Form CMS-1500 has been revised to accommodate reporting of the National Provider Identifier (NPI). The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at http://www.nucc.org/images/stories/PDF/change_log.pdf.

The Form CMS-1500 (08-05) version will be effective January 2007, but will not be mandated for use until April 2, 2007. Therefore, there will be a transition period during which either version of the Form-CMS-1500 can be submitted. In order to accommodate the transition period, both versions of the form need to be approved for use by the Office of Management and Budget (OMB). The current version of the Form CMS-1500 (12-90) version has been renewed by OMB through May 31, 2009. The OMB number for the Form CMS-1500 (12-90) version will continue to be 0938-0008. A new collection of the Form CMS-1500 (08-05) version has been approved by OMB under the collection number 0938-0999.

The following is the Form CMS-1500 timeline:

- January 2, 2007: Health plans, clearinghouses, and other information support vendors shall be ready to handle and accept the revised Form CMS-1500 (08/05).
- January 2, 2007 – March 30, 2007: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- April 2, 2007: The current Form CMS-1500 (12/90) version of the claim form is discontinued; only the revised Form CMS-1500 (08/05) is to be used. All rebilling of claims should use the revised Form CMS-1500 (08/05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12/90).

A. Background: A provision in the legislation allows for an additional year for small plans to comply with the NPI guidelines. Because of this provision, there may be a need to supply legacy IDs on COB claims through May 23, 2008. The CMS COB component will issue requirements for reporting of legacy numbers in COB claims after May 22, 2007.

B. Policy: The Form CMS-1500 answers the needs of many health insurers. It is the paper claim form prescribed by CMS for use by physicians and suppliers that qualify for an exemption from the mandatory

electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32.

In CR 4023, CMS required submitters of the Form CMS-1500 (12-90) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable. There are no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. In addition, Optical Character Readers (OCR) and shared system data entry screens would need to be modified to accept NPI's on that version of the form.

Form CMS-1500 (08-05) has split the provider identifier fields to enable NPI reporting (fields labeled as NPI) and corresponding legacy number reporting (unlabled block above each NPI field). CMS is applying the same NPI requirement to paper claims as to electronic claims. NPIs are to be used as the sole provider identifiers on all claims sent to a Medicare contractor May 23, 2007, and later. Between the time a provider receives an NPI and May 23, 2007, providers should report both NPIs and the corresponding legacy IDs when submitted on Form CMS-1500 (08-05). This applies to each provider identifier field in the form; if an NPI is entered, the corresponding legacy identifier should also be entered.

When rejecting, i.e., returning a claim to the submitter due to incorrect NPIs or legacy identifiers, using the X12 835 or a standard paper remittance (SPR), the following remark codes apply and would be used in conjunction with claim adjustment group CO and reason code 16:

N31 Missing/incomplete/invalid prescribing provider identifier.
N209 Missing/invalid/incomplete taxpayer identification number (TIN)
N253 Missing/incomplete/invalid attending provider primary identifier
N254 Missing/incomplete/invalid attending provider secondary identifier
N257 Missing/incomplete/invalid billing provider primary identifier
N259 Missing/incomplete/invalid billing provider secondary identifier
N262 Missing/incomplete/invalid operating provider primary identifier
N263 Missing/incomplete/invalid operating provider secondary identifier
N265 Missing/incomplete/invalid ordering provider primary identifier
N267 Missing/incomplete/invalid ordering provider secondary identifier
N270 Missing/incomplete/invalid other provider primary identifier
N271 Missing/incomplete/invalid other provider secondary identifier
N280 Missing/incomplete/invalid pay-to provider primary identifier
N282 Missing/incomplete/invalid pay-to provider secondary identifier
N283 Missing/incomplete/invalid purchased service provider identifier
N286 Missing/incomplete/invalid referring provider primary identifier
N287 Missing/incomplete/invalid referring provider secondary identifier
N290 Missing/incomplete/invalid rendering provider primary identifier
N291 Missing/incomplete/invalid rendering provider secondary identifier
N293 Missing/incomplete/invalid service facility primary identifier
N295 Missing/incomplete/invalid service facility secondary provider
N297 Missing/incomplete/invalid supervising provider primary identifier
N298 Missing/incomplete/invalid supervising provider secondary identifier

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5060.1	Shared system maintainers shall make all necessary shared system changes to receive, process, and store data from the revised Form CMS-1500 (08-05).						X	X		
5060.2	Shared system maintainers shall make all necessary shared system changes to accept NPI numbers in the revised Form CMS-1500 (08/05).						X	X		
5060.3	Shared system maintainers shall create edits to validate the NPI for length (10 bytes), for check digit, and for first position (1, 2, 3, or 4).						X	X		
5060.3.1	A claim shall be rejected, without appeal rights, in the most effective and efficient manner if the NPI number fails validation editing and include the reason for the rejection.			X	X		X	X		
5060.3.2	Shared system shall perform the following paper claim editing, during Stage 2, for each NPI in the claim for which there is also a Medicare legacy identifier reported for one or more providers.						X	X		
5060.3.2.1	Shared system shall search the crosswalk for each NPI.						X	X		
5060.3.2.2	If the NPI is located in the crosswalk, shared system shall determine if the legacy identifier in the claim matches a legacy identifier included in the same crosswalk entry as that NPI. A Medicare provider legacy identifier is qualified on paper claim with either 1C (Medicare provider) or 1G (UPIN).						X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5060.3.2.3	If either the reported NPI or the legacy number cannot be located in the crosswalk, the shared system shall reject the claim, without appeal rights, back to the submitter in the most effective and efficient manner, as unable to identify the provider.			X	X		X	X		
5060.3.2.4	The rejection message issued shall indicate which of the providers identified in the inbound claim could not be identified.			X	X		X	X		
5060.3.2.5	If the NPI and the legacy identifier both match, the shared system shall continue processing that claim.						X	X		
5060.3.3	Shared system shall perform the following paper claim editing, during Stage 2, for each NPI in the claim for which there is no Medicare provider legacy identifier submitted for a billing/pay-to, rendering, or performing provider.						X	X		
5060.3.3.1	Shared system shall search for the NPI in the crosswalk.						X	X		
5060.3.3.2	If the NPI is not located, contractors shall reject the transaction back to the submitter, without appeal rights, in the most effective and efficient manner, as unable to identify the provider as enrolled in Medicare.			X	X		X	X		
5060.3.3.3	The rejection message issued shall indicate which of the providers identified in the claim could not be identified.			X	X		X	X		
5060.3.4	If a provider legacy identifier is submitted on a revised Form CMS-1500 (08/05) without a corresponding NPI prior to May 23, 2007, the shared system shall process that transaction using pre-NPI edit, rejection, and processing requirements that applied to the submitted type of legacy identifier.						X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5060.4	Contractors shall set up a process to manually reject Form CMS-1500 (12-90) claims, received on or after April 2, 2007, and request that the claims be resubmitted on the Form CMS-1500 (08/05).			X	X					
5060.5	Contractors shall coordinate all OCR changes between their OCR vendor and their shared system maintainer.			X	X					
5060.6	When a paper claim has been processed that contained one or more NPIs that passed the NPI edits, but no corresponding legacy identifier for one or more of those NPIs, if COB applies, prior to May 23, 2007, the shared system maintainer shall: Obtain the legacy identifier from the crosswalk that applies to the NPI in the inbound claim for the billing, pay-to, rendering, or performing provider.						X	X		
5060.6.1	The shared system shall report those legacy identifier(s) in the appropriate 837 COB segments, data elements and loops with the 1C or 1G qualifier as applicable in the COB flat file.						X	X		
5060.6.2	The legacy identifier for other types of providers for which data was reported in the claim shall be reported in the COB flat file prior to May 23, 2007, if the NPI for those providers could be located in the crosswalk.						X	X		
5060.6.3	The shared system shall also report the TIN of the billing provider, when available, in a REF segment in the billing provider in the COB flat file.						X	X		
5060.7	Carriers and DMERCs shall enter the claim adjustment reason code and the remark codes listed at the end of the policy section of this CR into their shared system as needed for inclusion in an X12 835 or SPR due to an incorrect or missing NPI or legacy identifier.			X	X					DME MACs

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5060.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X	X					
5060.9	In addition to the above, contractors shall include information from this instruction in your next regularly scheduled bulletin, incorporate into any educational events on this topic, and post on your Web site. Within 1 week of the release of this instruction, you shall also include information from this instruction in a listserve message.			X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Claims received January 1, 2007 and after **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov **Post-Implementation Contact(s):** Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

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(Rev. 1058, 09-15-06)

10 - Health Insurance Claim Form CMS-1500

(Rev. 1058, Issued: 09-15-06; Effective: 01-01-07, Implementation: 01-02-07)

The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc. To purchase them from the U.S. Government Printing Office, call (202) 512-1800.

There are currently two versions of the Form CMS-1500. The current approved version of the form as of 2005 is the Form CMS-1500 (12/90). The current version is approved under the Office of Management and Budget (OMB) collection 0938-0008. The *revised* version of the form *is* Form CMS-1500 (08/05) and is *approved under the OMB collection 0938-0999.* The current claim form was revised to accommodate the implementation of the National Provider Identifier (NPI) which is scheduled for completion of the implementation in May 2007.

Between January 1, 2007, and March 31, 2007, either version of the Form CMS-1500 will be accepted by Medicare contractors. Therefore, you will find information within this chapter that applies to both claim forms. The differences between the two forms will be noted within the body of the text that describes each of the items/boxes/fields of the Form CMS-1500. In addition to the text within the chapter, there are two exhibits at the end of this chapter that provide the print file specifications for each form. Exhibit 1 is the print file specification layout for the current Form CMS-1500 (12-90) and Exhibit 2 is the print file specification layout for the Form CMS-1500 (08-05).

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. It has also been adopted by the *TRICARE Program* and has received the approval of the American Medical Association (AMA) Council on Medical Services.

There are a number of Part B services that have special limitations on payments or that require special methods of benefit computation. Carriers should monitor their processing systems to insure that they recognize the procedure codes that involve services with special payment limitations or calculation requirements. They should be able to identify separately billed procedure codes for physician services which are actually part of a global procedure code to prevent a greater payment than if the procedure were billed globally.

The following instructions must be completed or are required for a Medicare claim. Carriers should provide information on completing the Form CMS-1500 to all physicians and suppliers in their area at least once a year.

Providers may use these instructions *to complete* this form. The Form CMS-1500 has space for physicians and suppliers to provide information on other health insurance. This

information can be used by carriers to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is *another insurer to which Medicare can forward billing and payment data following adjudication if the provider is a physician or supplier that participates in Medicare.* (See Pub 100-05, Medicare Secondary Payer Manual, Chapter 3, and Chapter 28 *of* this manual).

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Legend	**Description**
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 1998 = 98)
CCYY	4 position Year (e.g., 1998 = 1998)
(MM | DD | YY) or (MM | DD | CCYY)	A space must be reported between month, day, and year (e.g., 12 | 15 | 98 or 12 | 15 | 1998). This space is delineated by a dotted vertical line on the Form CMS-1500)
(MMDDYY) or (MMDDCCYY)	No space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev. 1058, Issued: 09-15-06; Effective: 01-01-07, Implementation: 01-02-07)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to

treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);

- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;

- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

Item 17a – Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17. The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available.

NOTE: Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Pub 100-08, Chapter 14, Section 14.6 for additional information regarding UPINs.

Item 17b Form CMS-1500 (08-05) – Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as *January 1, 2007*.

NOTE: Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 – Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy

service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24K of this section.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a *non-participating physician/supplier who accepts assignment on a claim.* In this case, *payment can only be made directly to the beneficiary.*

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the PIN (or NPI when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, Chapter 1, Section 30.2.9.1 for additional information.)

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI when effective) of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician shall enter the Medicare facility provider number of the SNF in item 23.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24 (Form CMS-1500 (08-05) – The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. At this time, the shaded area *in 24a through 24h* is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in Section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H - Leave blank. Not required by Medicare.

Item 24I Form CMS-1500 (12-90) - Leave blank. Not required by Medicare.

Item 24I Form CMS-1500 (08-05) – Enter the ID qualifier 1C in the shaded portion.

Item 24J Form CMS-1500 (12-90) - Leave blank. Not required by Medicare.

Item 24J Form CMS-1500 (08-05) – Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.

Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than *January 1, 2007*, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

Item 24K Form CMS-1500 (12-90) - Enter the PIN of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24k.

Item 24K Form CMS-1500 (08-05) – There is no Item 24K on this version.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;

- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 Form CMS-1500 (12-90) - Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, *enter* the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.

Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 *shall* be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is

entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name, address, or PIN of the location where the order was accepted must be entered (DMERC only).

This field is required. When more than one supplier is used, a separate Form CMS-1500 *shall* be used to bill for each supplier.

This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed, and the PIN.

Item 32 Form CMS-1500 (08-05) - Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, *enter* the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 *shall* be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 *shall* be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a Form CMS-1500 (08-05) – Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as *January 1, 2007, and must be reported May 23, 2007, and later.*

Item 32b Form CMS-1500 (08-05) - Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Effective May 23, 2007, and later, 32b is not to be reported.

Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests.

For durable medical, orthotic, and prosthetic claims, enter the PIN (of the location where the order was accepted) if the name and address was not provided in item 32 (DMERC only).

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a Form CMS-1500 (08-05) - Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the Form CMS-1500 (08-05) as early as *January 1, 2007*. This is a required field.

Item 33b Form CMS-1500 (08-05) - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

Exhibit – 2

(Rev. 1058, Issued: 09-15-06; Effective: 01-01-07, Implementation: 01-02-07)

Form CMS-1500 (08/05) User Print File Specifications

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
1		Left printer alignment block	M	3	01-03
1		Right printer alignment block	M	3	77-79
3	1	Medicare	M	1	01
3	1	Medicaid	M	1	08
3	1	Tricare Champus	M	1	15
3	1	Champva	M	1	24
3	1	Group Health Plan	M	1	31
3	1	FECA Blk Lung	M	1	39
3	1	Other	M	1	45
3	1a	Insured's ID Number	A/N	29	50-78
5	2	Patient's Name (Last, First, MI)	A	28	01-28
5	3	Patient's Birth Date (Month)	N	2	31-32
5	3	Patient's Birth Date (Day)	N	2	34-35
5	3	Patient's Birth (Year)	N	4	37-40
5	3	Sex-Male	M	1	42
5	3	Sex-Female	M	1	47
5	4	Insured Name (Last, First, MI)	A	29	50-78
7	5	Patient's Address	A/N	28	01-28
7	6	Patient Relationship to Insured (Self)	M	1	33
7	6	Patient Relationship to Insured (Spouse)	M	1	38
7	6	Patient Relationship to Insured (Child)	M	1	42
7	6	Patient Relationship to Insured (Other)	M	1	47
7	7	Insured's Address	A/N	29	50-78
9	5	Patient's City	A	24	01-24
9	5	Patient's State	A	3	26-28
9	8	Patient Status (Single)	M	1	35
9	8	Patient Status (Married)	M	1	41
9	8	Patient Status (Other)	M	1	47
9	7	Insured's City	A	23	50-72
9	7	Insured's State	A	4	74-77
11	5	Patient's Zip Code	N	12	01-12
11	5	Patient's Area Code	N	3	15-17
11	5	Patient's Phone Number	N	10	19-28
11	8	Patient Status (Employed)	M	1	35
11	8	Patient Status (Full Time Student)	M	1	41
11	8	Patient Status (Part Time Student)	M	1	47
11	7	Insured's Zip Code	N	12	50-61

11	**7**	**Insured's Area Code**	**N**	**3**	**65-67**
11	**7**	**Insured's Phone Number**	**N**	**10**	**69-78**
13	**9**	**Other Insured's Name (Last, First, MI)**	**A**	**28**	**01-28**
13	**11**	**Insured's Policy, Group or FECA Number**	**A/N**	**29**	**50-78**
15	**9a**	**Other Insured's Policy or Group Number**	**A/N**	**28**	**01-28**
15	**10a**	**Condition Related (Employment C/P, Yes)**	**M**	**1**	**35**
15	**10a**	**Condition Related (Employment C/P, No)**	**M**	**1**	**41**
15	**11a**	**Insured's Date of Birth (Month)**	**N**	**2**	**53-54**
15	**11a**	**Insured's Date of Birth (Day)**	**N**	**2**	**56-57**
15	**11a**	**Insured's Date of Birth (Year)**	**N**	**4**	**59-62**
15	**11a**	**Sex-Male**	**M**	**1**	**68**
15	**11a**	**Sex-Female**	**M**	**1**	**75**
17	**9b**	**Other Insured's Date of Birth (Month)**	**N**	**2**	**02-03**
17	**9b**	**Other Insured's Date of Birth (Day)**	**N**	**2**	**05-06**
17	**9b**	**Other Insured's Date of Birth (Year)**	**N**	**4**	**08-11**
17	**9b**	**Sex-Male**	**M**	**1**	**18**
17	**9b**	**Sex-Female**	**M**	**1**	**24**
17	**10b**	**Condition Related To: (Auto Accident-Yes)**	**M**	**1**	**35**
17	**10b**	**Condition Related To: (Auto Accident-No)**	**M**	**1**	**41**
17	**10b**	**Condition Related To: (Auto Accident-State)**	**A**	**2**	**45-46**
17	**11b**	**Insured's Employer's Name or School Name**	**A/N**	**29**	**50-78**
19	**9c**	**Other Insured's Employer's Name or School**	**A/N**	**28**	**01-28**
19	**10c**	**Other Accident (Yes)**	**M**	**1**	**35**
19	**10c**	**Other Accident (No)**	**M**	**1**	**41**
19	**11c**	**Insured's Insurance Plan or PayerID**	**A/N**	**29**	**50-78**
21	**9d**	**Other Insured's Insurance Plan Name or PayerID**	**A/N**	**28**	**01-28**
21	**10d**	**(Reserved for Local Use)**	**A/N**	**19**	**30-48**
21	**11d**	**Another Benefit Health Plan (Yes)**	**M**	**1**	**52**
21	**11d**	**Another Benefit Health Plan (No)**	**M**	**1**	**57**
25	**12**	**Left Blank for Patient's Signature & Date**			
25	**13**	**Left Blank for Insured's Signature**			
27	**14**	**Date of Current Illness, Injury, Pregnancy (Month)**	**N**	**2**	**02-03**
27	**14**	**Date of Current Illness, Injury, Pregnancy (Day)**	**N**	**2**	**05-06**
27	**14**	**Date of Current Illness, Injury, Pregnancy - (Year)**	**N**	**4**	**08-11**
27	**15**	**First Date Has Had Same or Similar Illness (Month)**	**N**	**2**	**37-38**
27	**15**	**First Date Has Had Same or Similar Illness (Day)**	**N**	**2**	**40-41**
27	**15**	**First Date Has Had Same or Similar Illness - (Year)**	**N**	**4**	**43-46**
27	**16**	**Dates Patient Unable to Work (From Month)**	**N**	**2**	**54-55**
27	**16**	**Dates Patient Unable to Work (From Day)**	**N**	**2**	**57-58**
27	**16**	**Dates Patient Unable to Work (From Year)**	**N**	**4**	**60-63**
27	**16**	**Dates Patient Unable to Work (To Month)**	**N**	**2**	**68-69**
27	**16**	**Dates Patient Unable to Work (To Day)**	**N**	**2**	**71-72**
27	**16**	**Dates Patient Unable to Work (To Year)**	**N**	**4**	**74-77**
28	**17a**	**Legacy Qualifier/Provider Number of Referring Physician**	**A/N**	**19**	**30-48**

29	**17**	**Name of Referring Physician or Other Source**	**A**	**26**	**01-26**
29	**17b**	**NPI Number of Referring Physician**	**N**	**17**	**32-48**
29	**18**	**Hospitalization Related Current Svcs (From Month)**	**N**	**2**	**54-55**
29	**18**	**Hospitalization Related Current Svcs (From Day)**	**N**	**2**	**57-58**
29	**18**	**Hospitalization Related Current Svcs (From Year)**	**N**	**4**	**60-63**
29	**18**	**Hospitalization Related Current Svcs (To Month)**	**N**	**2**	**68-69**
29	**18**	**Hospitalization Related Current Svcs (To Day)**	**N**	**2**	**71-72**
29	**18**	**Hospitalization Related Current Svcs (To Year)**	**N**	**4**	**74-77**
30	**19**	**Reserved for Local Use**	**A/N**	**35**	**14-48**
31	**19**	**Reserved for Local Use**	**A/N**	**48**	**01-48**
31	**20**	**Outside Lab (Yes)**	**M**	**1**	**52**
31	**20**	**Outside Lab (No)**	**M**	**1**	**57**
31	**20**	**$ Charges**	**N**	**8/8**	**62-78**
33	**21.1**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**03-10**
33	**21.3**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**30-37**
33	**22**	**Medicaid Resubmission Code**	**A/N**	**11**	**50-60**
33	**22.2**	**Original Reference Number**	**A/N**	**18**	**61-78**
35	**21.2**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**03-10**
35	**21.4**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**30-37**
35	**23**	**Prior Authorization Number**	**A/N**	**29**	**50-78**
38	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
38	**24.1i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
38	**24.1j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
39	**24.1a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
39	**24.1a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
39	**24.1a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
39	**24.1a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
39	**24.1a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
39	**24.1a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
39	**24.1b**	**Place of Service**	**A/N**	**2**	**19-20**
39	**24.1c**	**EMG**	**A**	**2**	**22-23**
39	**24.1d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	***6***	**25-30**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	***2***	**36-37**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	***2***	**42-43**
39	**24.1e**	**Diagnosis Pointer**	**N**	***4***	**45-48**
39	**24.1f**	**$ Charges**	**N**	**8**	**50-57**
39	**24.1g**	**Days or Units**	**N**	**3**	**59-61**
39	**24.1h**	**EPSDT Family Plan**	**A**	**1**	**63**
39	**24.1i**	**Legacy Qualifier Rendering Provider (Leave Blank)**	**A/N**	**0**	
39	**24.1j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
40	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
40	**24.2i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**

40	**24.2j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
41	**24.2a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
41	**24.2a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
41	**24.2a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
41	**24.2a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
41	**24.2a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
41	**24.2a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
41	**24.2b**	**Place of Service**	**A/N**	**2**	**19-20**
41	**24.2c**	**EMG**	**A**	**2**	**22-23**
41	**24.2d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	***6***	**25-30**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	***2***	**36-37**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	***2***	**42-43**
41	**24.2e**	**Diagnosis Pointer**	**N**	***4***	**45-48**
41	**24.2f**	**$ Charges**	**N**	**8**	**50-57**
41	**24.2g**	**Days or Units**	**N**	**3**	**59-61**
41	**24.2h**	**EPSDT Family Plan**	**A**	**1**	**63**
41	**24.2i**	**Legacy Qualifier Rendering Provider (Leave Blank)**	**A/N**	**0**	
41	**24.2j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
42	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
42	**24.3i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
42	**24.3j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
43	**24.3a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
43	**24.3a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
43	**24.3a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
43	**24.3a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
43	**24.3a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
43	**24.3a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
43	**24.3b**	**Place of Service**	**A/N**	**2**	**19-20**
43	**24.3c**	**EMG**	**A**	**2**	**22-23**
43	**24.3d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	***6***	**25-30**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	***2***	**36-37**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	***2***	**42-43**
43	**24.3e**	**Diagnosis Pointer**	**N**	***4***	**45-48**
43	**24.3f**	**$ Charges**	**N**	**8**	**50-57**
43	**24.3g**	**Days or Units**	**N**	**3**	**59-61**
43	**24.3h**	**EPSDT Family Plan**	**A**	**1**	**63**
43	**24.3i**	**Legacy Qualifier Rendering Provider (Leave Blank)**	**A/N**	**0**	
43	**24.3j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
44	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
44	**24.4i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**

44	24.4j	Legacy Provider Number Rendering Provider	A/N	11	68-78
45	24.4a	Date(s) of Service - (From Month)	N	2	01-02
45	24.4a	Date(s) of Service - (From Day)	N	2	04-05
45	24.4a	Date(s) of Service - (From Year)	N	2	07-08
45	24.4a	Date(s) of Service - (To Month)	N	2	10-11
45	24.4a	Date(s) of Service - (To Day)	N	2	13-14
45	24.4a	Date(s) of Service - (To Year)	N	2	16-17
45	24.4b	Place of Service	A/N	2	19-20
45	24.4c	EMG	A	2	22-23
45	24.4d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	*6*	25-30
45	24.4d	Procedures, Svcs or Supplies (Modifier 1)	A/N	2	33-34
45	24.4d	Procedures, Svcs or Supplies (Modifier 2)	A/N	*2*	36-37
45	24.4d	Procedures, Svcs or Supplies (Modifier 3)	A/N	2	39-40
45	24.4d	Procedures, Svcs or Supplies (Modifier 4)	A/N	*2*	42-43
45	24.4e	Diagnosis Pointer	N	*4*	45-48
45	24.4f	$ Charges	N	8	50-57
45	24.4g	Days or Units	N	3	59-61
45	24.4h	EPSDT Family Plan	A	1	63
45	24.4i	Legacy Qualifier Rendering Provider (Leave Blank)	A/N	0	
45	24.4j	Legacy Provider Number Rendering Provider	A/N	11	68-78
46	24	Line Detail Narrative	A/N	63	01-63
46	24.5i	Legacy Qualifier Rendering Provider	A/N	2	65-66
46	24.5j	Legacy Provider Number Rendering Provider	A/N	11	68-78
47	24.5a	Date(s) of Service - (From Month)	N	2	01-02
47	24.5a	Date(s) of Service - (From Day)	N	2	04-05
47	24.5a	Date(s) of Service - (From Year)	N	2	07-08
47	24.5a	Date(s) of Service - (To Month)	N	2	10-11
47	24.5a	Date(s) of Service - (To Day)	N	2	13-14
47	24.5a	Date(s) of Service - (To Year)	N	2	16-17
47	24.5b	Place of Service	A/N	2	19-20
47	24.5c	EMG	A	2	22-23
47	24.5d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	*6*	25-30
47	24.5d	Procedures, Svcs or Supplies (Modifier 1)	A/N	2	33-34
47	24.5d	Procedures, Svcs or Supplies (Modifier 2)	A/N	*2*	36-37
47	24.5d	Procedures, Svcs or Supplies (Modifier 3)	A/N	2	39-40
47	24.5d	Procedures, Svcs or Supplies (Modifier 4)	A/N	*2*	42-43
47	24.5e	Diagnosis Pointer	N	*4*	45-48
47	24.5f	$ Charges	N	8	50-57
47	24.5g	Days or Units	N	3	59-61
47	24.5h	EPSDT Family Plan	A	1	63
47	24.5i	Legacy Qualifier Rendering Provider (Leave Blank)	A/N	0	
47	24.5j	Legacy Provider Number Rendering Provider	A/N	11	68-78
48	24	Line Detail Narrative	A/N	63	01-63
48	24.6i	Legacy Qualifier Rendering Provider	A/N	2	65-66

48	**24.6j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
49	**24.6a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
49	**24.6a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
49	**24.6a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
49	**24.6a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
49	**24.6a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
49	**24.6a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
49	**24.6b**	**Place of Service**	**A/N**	**2**	**19-20**
49	**24.6c**	**EMG**	**A**	**2**	**22-23**
49	**24.6d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	***6***	**25-30**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	***2***	**36-37**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	***2***	**42-43**
49	**24.6e**	**Diagnosis Pointer**	**N**	***4***	**45-48**
49	**24.6f**	**$ Charges**	**N**	**8**	**50-57**
49	**24.6g**	**Days or Units**	**N**	**3**	**59-61**
49	**24.6h**	**EPSDT Family Plan**	**A**	**1**	**63**
49	**24.6i**	**Legacy Qualifier Rendering Provider (Leave Blank)**	**A/N**	**0**	
49	**24.6j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
51	**25**	**Federal Tax ID Number**	**N**	**15**	**1-15**
51	**25**	**Federal Tax ID Number (SSN)**	**M**	**1**	**17**
51	**25**	**Federal Tax ID Number (EIN)**	**M**	**1**	**19**
51	**26**	**Patient's Account Number**	**A/N**	**14**	**23-36**
51	**27**	**Accept Assignment (Yes)**	**M**	**1**	**38**
51	**27**	**Accept Assignment (No)**	**M**	**1**	**43**
51	**28**	**Total Charge**	**N**	**9**	**51-59**
51	**29**	**Amount Paid**	**N**	**8**	**62-69**
51	**30**	**Balance Due**	**N**	**8**	**71-78**
52	**33**	**Billing Provider Phone Number Area Code**	**N**	**3**	**66-68**
52	**33**	**Billing Provider Phone Number**	**N**	**9**	**70-78**
53	**32**	**Name of Facility Where Svcs Rendered**	**A/N**	**26**	**23-48**
53	**33**	**Physician/Supplier Billing Name**	**A/N**	**29**	**50-78**
54	**32**	**Address of Facility Where Svcs Rendered**	**A/N**	**26**	**23-48**
54	**33**	**Physician/Supplier Address**	**A/N**	**29**	**50-78**
55	**31**	**Left Blank for Signature Physician/Supplier**			
55	**32**	**City, State and Zip Code of Facility**	**A/N**	**26**	**23-48**
55	**33**	**City, State and Zip Code of Billing Provider**	**A/N**	**29**	**50-78**
56	**32a**	**Facility NPI Number**	**N**	**10**	**24-33**
56	**32b**	**Facility Qualifier and Legacy Number**	**A/N**	**14**	**35-48**
56	**33a**	**Billing Provider NPI Number**	**N**	**10**	**51-60**
56	**33b**	**Billing Provider Qualifier and Legacy Number**	**A/N**	**17**	**62-78**

*** M = mark (X), A = alpha, N = numeric**