CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1970	**Date: May 21, 2010**
	Change Request 6929

Transmittal 1970 is being re-communicated to correct the effective and implementation dates in the manual instruction. The correct effective date is October 1, 2010 and the correct implementation date is October 4, 2010. The transmittal number, date issued and all other information remain the same."

SUBJECT: Updated Form CMS-1500 Information

I. SUMMARY OF CHANGES: This Change Request provides updated language to Pub. 100-04, chapter 26 related to general Form CMS-1500 information by removing language allowing the use of legacy identifiers. The information in section 10.9 is being moved to section 10. Therefore, the information in sections 10.10 and 10.10.1 is being moved to section 10.9 and the new section 10.9.1 respectively, due to the re-numbering of these sections. As a result, only the section numbers 10.10 and 10.10.1 are being deleted. Additionally, Exhibit 1, the 12/90 version of Form CMS-1500 print specifications, is being deleted therefore, Exhibit 2, the 08/05 version of the print specifications, will become Exhibit 1.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is 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	26/10.4/Items 14-33 - Provider of Service or Supplier Information
R	26/10.9/Miles/Times/Units/Services (MTUS)
N	26/10.9.1/Methodology for Coding Number of Services, MTUS Count and MTUS Indicator Fields
D	26/10.10/Miles/Times/Units/Services (MTUS)

D	26/10.10.1/ Methodology for Coding Number of Services, MTUS Count and MTUS Indicator Fields
R	26/30/Exhibit 1 - Form CMS-1500 (08-05) User Print File Specifications (Formerly Exhibit 2)
D	26/30/Exhibit 2 - Form CMS-1500 (08-05) User Print File Specifications

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1970	Date: May 21, 2010	Change Request: 6929

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SUBJECT: Updated Form CMS-1500 Information

Effective Date: October 1, 2010
Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: This Change Request provides updated language to Pub. 100-04, chapter 26 related to general Form CMS-1500 information by removing language allowing the use of legacy identifiers. The information in section 10.9 is being moved to section 10. Therefore, the information in sections 10.10 and 10.10.1 is being moved to section 10.9 and the new section 10.9.1 respectively, due to the re-numbering of these sections. As a result, only the section numbers 10.10 and 10.10.1 are being deleted. Additionally, Exhibit 1, the 12/90 version of Form CMS-1500 print specifications, is being deleted therefore, Exhibit 2, the 08/05 version of the print specifications, will become Exhibit 1.

B. Policy: 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.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6929.1	Contractors shall be in compliance with the instructions found in Pub. 100-04, Medicare Claims Processing Manual, chapter 26.	X	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6929.2	A provider education article related to this instruction will	X	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	be available at http://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 sites 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 the Contractors next regularly scheduled bulletin. 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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Contact Brian Reitz, 410-786-5001, brian.reitz@cms.hhs.gov.

Post-Implementation Contact(s): Contact Brian Reitz, 410-786-5001, brian.reitz@cms.hhs.gov.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

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

Table of Contents

(Rev. 1970, 05-21-10)

10 - Health Insurance Claim Form CMS-1500

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-10, Implementation: 10-04-10)

The current version of the form is Form CMS-1500 (08/05) and is approved under the OMB collection 0938-0999. 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.

Carriers, physicians, and suppliers are responsible for purchasing their own Form CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as they follow the CMS approved specifications (see section 30) developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. To purchase *forms* from the U.S. Government Printing Office, call (202) 512-1800.

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 *or A/B MACs* 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 *or A/B MACs* 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 *or A/B MACs* 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 <u>all</u> these fields. For instance, a provider of service or supplier will <u>not</u> 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)

Legend	Description
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. 1970, Issued: 05-21-10, Effective: 10-01-10, Implementation: 10-04-10)

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. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring 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. 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 – *Leave blank*.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 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 NPI 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 NPI of an ordering/referring/attending/certifying physician or non-physician practitioner is 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 17b, and for the identification of the supervisor, see item 24J of this section.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

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, is 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 NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

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.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition 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 anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple anti-markup 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 the anti-markup payment limitation.

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 NPI 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.

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

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate 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.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

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 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 - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's NPI number in the lower unshaded 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 unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

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 - 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 anti-markup tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

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 (DME MAC 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 - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - Effective May 23, 2008, Item 32b is not to be reported.

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

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Effective May 23, 2008, Item 33b is not to be reported.

10.9 - *Miles/Times/Units/Services (MTUS)*

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-10, Implementation: 10-04-10)

Miles/Times/Units/Services (MTUS) count and MTUS indicator fields are on Part B Physician/Supplier Claims. These fields are documented in the CMS National Claims History Data Dictionary.

Standard systems are to put MTUS count and MTUS indicators on all claims at the line item level.

The purpose of the MTUS Count Field on the line item is to document additional information reflecting certain volumes related to indicators. In most cases, the value in this field will be the same as in the Service Count Field on the line item; however, for services such as anesthesia the field values will differ. In this case, the service count field will likely contain a value of 1 for the occurrence of the surgery while the MTUS Count Field will contain the actual time units that the anesthesiologist spent with the patient in 15 minute increments or a fraction thereof.

The purpose of the MTUS Indicator Field is to indicate what the value entered into the MTUS Count Field means. There are 6 indicator values, as follows:

0 - No allowed services
1 - Ambulance transportation miles
2 - Anesthesia Time Units
3 - Services
4 - Oxygen units
5 - Units of Blood

Examples of how to code these fields are specified in §10.10.1 below.

10.9.1 - Methodology for Coding Number of Services, MTUS Count and MTUS Indicator Fields

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-10, Implementation: 10-04-10)

The following instructions should be used as a guide for coding the number of services, MTUS Count and MTUS Indicator fields on the Part B Physician/Supplier Claim. These fields are documented in the CMS National Claims History Data Dictionary as CWFB_SRVC_CNT, CWFB_MTUS_CNT, and CWFB_MTUS_IND_CD, respectively. Services not falling into examples B, C, E, or F should be coded as shown in example D (services/pricing units).

A. No Allowed Services – (CWFB_MTUS_IND_CD = 0)

For claims reporting no allowed services, the following example should be used to code the line item:

A total of 2 visits was reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient. Both services were denied.

Number of services:	2 (furnished)
MTUS (services):	0 (allowed)
MTUS indicator:	0

B. Ambulance Miles - (CWFB_MTUS_IND_CD = 1)

For claims reporting ambulance miles, the following example should be used to code the line item:

Mileage Reporting: A total of 10 miles (1 trip) was reported for HCPCS code A0425: Ground mileage, per statute mile.

Number of services:	10
MTUS (miles):	10
MTUS indicator:	1

C. Anesthesia Time Units - (CWFB_MTUS_IND_CD = 2)

For claims reporting anesthesia time units in 15-minute periods or fractions of 15-minute periods, the following example should be used to code the line item:

A total of 1 allowed service is reported for HCPCS code 00142: Anesthesia for procedures on eye; lens surgery. The anesthesiologist attended the patient for 35 minutes.

Number of services: 1
MTUS (time units): 23 (one decimal point implied) *****
MTUS indicator: 2

***** Two 15-minute periods + 1/3 of a 15-minute period equals 2.3

D. Services/Pricing Units - (CWFB_MTUS_IND_CD = 3)

For claims reporting a service or pricing unit, the following examples should be used to code the line item:

Example 1-A total of 2 visits was reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient.

Number of services: 2
MTUS (services): 2
MTUS indicator: 3

Example 2 - A total of 500 milligrams was administered for HCPCS code J0120: Injection, Tetracycline, up to 250 mg.

NOTE: The number of milligrams should not be reported in the service or MTUS fields. Instead, report the number of pricing units. In this case, up to 250 mg equals 1 unit/service. Thus, 500 mg equals 2 units/services.

Number of services: 2
MTUS (services): 2
MTUS indicator: 3

Example 3-A total of 24 cans was purchased, each containing 300 calories for HCPCS code B4150: Enteral Formulae, 100 calories.

NOTE: Neither number of cans nor the number of calories should be reported in the services or MTUS fields. Instead, report the number of pricing units. In this case, 100 calories equals 1 unit/service. Thus, 24 cans * 300 calories / 100 calories equals 72 units/services.

Number of services: 72
MTUS (services): 72
MTUS indicator: 3

E. Oxygen Services - (CWFB_MTUS_IND_CD = 4)

For claims reporting oxygen units, the following example should be used to code the line item:

A total of 2 allowed services was reported for HCPCS code E0441: Oxygen contents, gaseous, 1 month's supply = 1 unit. The claim reported a 2 month's supply of oxygen.

Number of services: 2
MTUS: 2
MTUS indicator: 4

F. Blood Services - (CWFB_MTUS_IND_CD = 5)

For claims reporting blood units, the following example should be used to code the line item:

A total of 6 units of blood (services) was furnished for HCPCS code P9010: Blood (whole), for transfusion, per unit. Two units were denied**.**

Number of services: 6 (furnished)
MTUS (units): 4 (allowed)
MTUS indicator: 5

Exhibit *1*

(Rev.1970, 05-21-10)

Form CMS-1500 (08/05) User Print File Specifications *(Formerly Exhibit 2)*

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**