

CMS-1500 Completion

The *Health Insurance Claim Form (CMS-1500)* is used by Allied Health professionals, physicians, laboratories and pharmacies to bill supplies and services to the Medi-Cal program. Providers are required to purchase *CMS-1500* claim forms from a vendor. Claim forms ordered through vendors must include red “drop-out” ink.

Most claims for these services and supplies may also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual.

For additional billing information, refer to the *CMS-1500 Special Billing Instructions*, *CMS-1500 Submission and Timeliness Instructions* and the *CMS-1500 Tips for Billing* sections in this manual.

Notice: Claim completion instructions for the new (02/12) version of the *CMS-1500* are included in the first half of this manual section. Claim completion instructions for the previous (08/05) version of the *CMS-1500* are retained in the second half of this section. Claims on the new version will be accepted for processing beginning January 6, 2014. Claims on the old version will be processed through March 31, 2014. Beginning April 1, 2014, only the 02/12 version of the *CMS-1500* will be accepted by Medi-Cal.

Medicare/Medi-Cal Billing for Medical Supplies

Medicare covers certain medical supplies, listed in the *Medical Supplies: Medicare Covered Services* section of the appropriate Part 2 manual. Providers must bill Medicare prior to billing Medi-Cal for these medical supplies. Most Medicare-approved claims will cross over to Medi-Cal automatically. However, if for some reason this does not occur, providers must bill Medicare-covered medical supplies to Medi-Cal as crossover claims on the *CMS-1500* claim form with proof of Medicare billing attached. (Medi-Cal does not accept direct-to-Medi-Cal crossover claims from providers electronically. Providers must submit these claims on paper.)

For more detailed crossover billing information, refer to the appropriate *Medicare/Medi-Cal Crossover Claims* section in this manual.

Durable Medical Equipment (DME)

Pharmacies that dispense Durable Medical Equipment (DME) or orthotic or prosthetic devices must bill for them on the *CMS-1500* and must be enrolled in the proper category of service with the Department of Health Care Services (DHCS), Provider Enrollment Division (PED).

Pharmacies billing on the *CMS-1500* may also bill DME using the CMC Medical Record (Claim Type 5) or the ASC X12N 837 Professional v.5010. Pharmacies billing DME electronically are subject to the enrollment requirements specified above.

Blood

Pharmacies billing for blood derivatives and cryoprecipitates (frozen blood) must bill on the *CMS-1500*.

CMS-1500 VERSION 02/12 COMPLETION DIRECTIONS

Claim Completion Differences

The 02/12 version of the *CMS-1500* is illustrated on the following page. At present providers enter exactly the same information in each field as they entered on the previous 08/05 version of the *CMS-1500*, with the following exceptions:

Box 17: Data in the *Name of Referring Provider or Other Source* field (Box 17) must be indented. The space to the left of the vertical dotted line must remain blank.

Box 21: Data is not required in the *ICD Ind.* area of this box until September 22, 2014.

HEALTH INSURANCE CLAIM FORM														
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12														
PICA <input type="checkbox"/>					PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ADN/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) MEDI-CAL ID NUMBER									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT'S LAST NAME, FIRST NAME					3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) MOTHER'S NAME FOR NEWBORN				
5. PATIENT'S ADDRESS (No., Street) PATIENT'S COMPLETE ADDRESS					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)				
CITY PATIENT'S CITY					STATE ST					CITY				
ZIP CODE PATIENT'S 9-DIGIT ZIP					TELEPHONE (Include Area Code) (PATIENT'S PHONE					ZIP CODE				
TELEPHONE (Include Area Code)														
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					SEX M <input type="checkbox"/> F <input type="checkbox"/>				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE CARRIER CODE				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below. SIGNED NA DATE NA					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER COVERAGE/AMOUNT If yes, complete items 9, 9a, and 9d.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY ONSET DATE					15. OTHER DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY NA				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE NAME OF REFERRING PROVIDER					17a. NPI NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM DOS TO DOS				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ADDITIONAL JUSTIFICATION PLACED HERE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					22. RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.					23. PRICR AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER				
A. [DIAGNOSIS CODE 1]					B. [DIAGNOSIS CODE 2]					C. [DIAGNOSIS CODE 3]				
E. [DIAGNOSIS CODE 5]					F. [DIAGNOSIS CODE 6]					G. [DIAGNOSIS CODE 7]				
I. [DIAGNOSIS CODE 9]					J. [DIAGNOSIS CODE 10]					K. [DIAGNOSIS CODE 11]				
L. [DIAGNOSIS CODE 12]					F. \$ CHARGES					G. DAYS OR UNITS				
H. ICD-9-CM					I. ICD-10					J. RENDERING PROVIDER ID #				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER					25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NUMBER				
27. ACCEPT ASSIGNMENT? (For gov. plans, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE TOTAL CHARGES					29. AMOUNT PAID TOTAL DEDUCTIONS				
30. Billing Provider Info & PH # (PHONE NUMBER)					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE OF PROVIDER OR PERSON AUTHORIZED					32. SERVICE FACILITY LOCATION INFORMATION NAME AND ADDRESS OF SERVICE FACILITY				
33. BILLING PROVIDER INFO & PH # (PHONE NUMBER)					34. FACILITY NPI					35. NON-NPI NUMBER				
36. BILLER NPI					37. NON-NPI NUMBER									

Figure 1. CMS-1500 Version 02/12: Medi-Cal-Required Fields.

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *CMS-1500* on the previous page and are unique to Medi-Cal. All items must be completed unless otherwise noted in these instructions.

Note: Items described as “Not required by Medi-Cal” (NA) may be completed for other payers but are not recognized by the Medi-Cal claims processing system.

UNDESIGNATED WHITE SPACE. Do not type in the top one inch of the *CMS-1500* claim form, because this area is reserved for fiscal intermediary use.

Item Description

1. **MEDICAID/MEDICARE/OTHER ID.** If the claim is a Medi-Cal claim, enter an “X” in the Medicaid box. If submitting a Medicare/Medi-Cal crossover claim, use a copy of the original *CMS-1500* billed to Medicare and enter an “X” in both the *Medicaid* and *Medicare* boxes.

Note: For more information about crossover claims, refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.

1a. **INSURED’S ID NUMBER.** Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

Newborn Infant

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother’s ID number in this field. (For more information, see Item 2 on a following page.)

Newborn Infant

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 2. | <p>PATIENT’S NAME. Enter the recipient’s last name, first name, and middle initial (if known). Avoid nicknames or aliases.</p> <p>When submitting a claim for a newborn infant using the mother’s ID number, enter the infant’s name in Box 2. If the infant has not yet been named, write the mother’s last name followed by “Baby Boy” or “Baby Girl” (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn also must be designated by a number or letter (example: Jones Baby Girl Twin A). Providers may also wish to use the <i>Patient’s Account No.</i> field (Box 26) to enter Twin A (or B). This is not a required field, and only for provider convenience. This field is repeated in all payment information (such as the <i>Remittance Advice Details [RAD]</i>), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.</p> <p>Enter the infant’s sex and date of birth in Box 3, and check the <i>Child</i> box in Box 6 (<i>Patient’s Relationship to Insured</i>). Enter the mother’s name in Box 4 (<i>Insured’s Name</i>).</p> <p>Services rendered to an infant may be billed with the mother’s ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number. To facilitate reimbursement for infants (including twins) using the mother’s ID number, enter NEWBORN INFANT USING MOTHER’S ID in the <i>Additional Claim Information</i> (Box 19) or NEWBORN INFANT USING MOTHER’S ID (TWIN A) or (TWIN B).</p> |
| 3. | <p>PATIENT’S BIRTH DATE/SEX. Enter the recipient’s date of birth in six-digit MMDDYY (Month, Day, Year) format (for example, September 1, 1963 = 090163). If the recipient’s full date of birth is not available, enter the year preceded by 0101. (For newborns, see Item 2.)</p> <p>If the recipient is 100 years or older, enter the recipient’s age and the full <u>four</u>-digit year of birth in the <i>Additional Claim Information</i> field (Box 19).</p> <p>Enter an “X” in the “M” or “F” box. Obtain the sex indicator from the BIC. (For newborns, see Item 2.)</p> |
| 4. | <p>INSURED’S NAME. Not required by Medi-Cal, except when billing for an infant using the mother’s ID. Enter the mother’s name in this field when billing for the infant.</p> |

<u>Item</u>	<u>Description</u>
5.	PATIENT'S ADDRESS/TELEPHONE. Enter recipient's complete address and telephone number.
6.	PATIENT RELATIONSHIP TO INSURED. Not required by Medi-Cal. This field may be used when billing for an infant using the mother's ID by checking the <i>Child</i> box.
7.	INSURED'S ADDRESS. Not required by Medi-Cal.
8.	RESERVED FOR NUCC USE. Not required by Medi-Cal.
9.	OTHER INSURED'S NAME. Not required by Medi-Cal.
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER. Not required by Medi-Cal.
9b.	RESERVED FOR NUCC USE. Not required by Medi-Cal.
9c.	RESERVED FOR NUCC USE. Not required by Medi-Cal.
9d.	INSURANCE PLAN NAME OR PROGRAM NAME. Not required by Medi-Cal.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 10. | IS PATIENT'S CONDITION RELATED TO: |
| 10a. | EMPLOYMENT. Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the <i>Date of Current Illness, Injury or Pregnancy</i> field (Box 14). |
| 10b. | AUTO ACCIDENT/PLACE. Not required by Medi-Cal. |
| 10c. | OTHER ACCIDENT. Not required by Medi-Cal. |
| 10d. | CLAIM CODES (Designated by NUCC). Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about SOC, refer to the <i>Share of Cost (SOC)</i> section in the Part 1 manual. Also refer to the <i>Share of Cost (SOC): CMS-1500</i> section or the <i>Share of Cost (SOC): 30-1 for Pharmacy</i> section in the appropriate Part 2 manual. |
| 11. | INSURED'S POLICY GROUP OR FECA NUMBER. Not required by Medi-Cal. |
| 11a. | INSURED'S DATE OF BIRTH/SEX. Not required by Medi-Cal. |
| 11b. | OTHER CLAIM ID (Designated by NUCC). Not required by Medi-Cal. |

<u>Item</u>	<u>Description</u>
11c.	<p>INSURANCE PLAN NAME OR PROGRAM NAME. For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.</p>
11d.	<p>IS THERE ANOTHER HEALTH BENEFIT PLAN. Enter an “X” in the Yes box if recipient has Other Health Coverage (OHC). OHC includes insurance carriers, Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) who provide any of the recipient’s health care needs. Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered Other Health Coverage.</p> <p>Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Part 1 manual.</p> <p>If the Other Health Coverage has paid, enter the amount in the upper right side of this field as shown in <i>Figure 2</i> on a following page in this section. Do not enter a decimal point (.) or dollar sign (\$).</p>

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 12. | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE.
Not required by Medi-Cal. |
| 13. | INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.
Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box. |
| 14. | DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP). Enter the date of onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP). Medi-Cal does not require a qualifier (QUAL) in this field. |
| 15. | OTHER DATE. Not required by Medi-Cal. |
| 16. | DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION. Not required by Medi-Cal. |

<u>Item</u>	<u>Description</u>
17.	<p>NAME OF REFERRING PROVIDER OR OTHER SOURCE. Indent to the right of the dotted line and enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the non-physician medical practitioner must be entered.</p> <p>Note: Providers billing lab service for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.</p>
17a.	<p>UNLABELED. Not required by Medi-Cal.</p>
17b.	<p>NPI. Enter the National Provider Identifier (NPI).</p> <p>Boxes 17 and 17b <u>must</u> be completed by the following providers:</p> <ul style="list-style-type: none">• Clinical laboratory (services billed by laboratory)• Durable Medical Equipment (DME) and medical supply• Hearing aid dispenser• Orthotist• Prosthetist• Nurse anesthetist• Occupational therapist• Physical therapist• Podiatrist (when services are rendered in a Skilled Nursing Facility [NF Level A or B])• Portable X-ray• Radiologist• Speech pathologist• Audiologist• Pharmacies

Item Description

Boxes 17 and 17b (continued)

In-State Referring Provider

A Universal Provider Information Number (UPIN) is not allowed.

Out-of-State Referring Provider

Claims must include a referring provider number using the referring provider's individual (not group) number. A license number or UPIN is not allowed.

Dental Referring Providers: In-State

Claims must include a referring provider number . Add the prefix "DDS" to the referring provider license number on the claim. A provider number or UPIN is not allowed.

Dental Referring Providers: Out-of-State

Claims must include a referring provider number. Add the prefix "DEN" to the referring provider license number on the claim. UPINs are not allowed.

A non-physician medical practitioner authorized to refer with the physician's provider number should include the number of the supervising physician on the referral. The billing provider also should enter the number of the supervising physician. Claims with a non-physician medical practitioner number will not be reimbursed.

When a billing provider receives a *Resubmission Turnaround Document* (RTD) or denial due to an invalid referring provider number, the referring provider should be contacted to verify the status of the provider number.

A physician's assistant (and other non-physician practitioners authorized to refer with the physician's number) should include the provider number of the supervising physician on the referral. The billing provider should enter the provider number of the supervising physician. Claims with a Non-physician Medical Practitioner (NMP) license number will not be reimbursed.

Note: Referring providers who would like to participate in the Medi-Cal program may contact the Telephone Service Center (TSC) at 1-800-541-5555.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 18. | HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank. |
| 19. | ADDITIONAL CLAIM INFORMATION (Designated by NUCC). Use this area for procedures that require additional information or justification. For specific “By Report” attachment requirements, refer to the <i>CMS-1500 Special Billing Instructions</i> section of this manual. |

Attachments

Claims for “By Report” codes, complicated procedures (modifier 22), unlisted services and anesthesia time require attachments. This information may also be entered in the *Additional Claim Information* field (Box 19) if space permits.

Reports are not required for routine procedures. Non-reimbursable CPT-4 codes are listed in the *TAR and Non-Benefit List: Codes 10000 – 99999* sections of the appropriate Part 2 manual. Refer to “Attachments” in the *CMS-1500 Special Billing Instructions* section in this manual, the CPT-4 book or in the appropriate policy sections for details.

Note: Please do not staple attachments.

<u>Item</u>	<u>Description</u>
20.	<p>OUTSIDE LAB? If this claim includes charges for laboratory work performed by a licensed laboratory, enter an “X.” “Outside” laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank if not applicable.</p> <p>OUTSIDE LAB \$ CHARGES. Not required by Medi-Cal.</p>
21.	<p>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A–L to service line below (24E).</p> <p>ICD Ind. Enter the ICD indicator “9” for claims that will be received by the Fiscal Intermediary on or after September 22, 2014. Claims submitted without a diagnosis code do not require an ICD indicator.</p>
21.A	<p>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Enter all letters and/or numbers of the ICD-9-CM code for the <u>primary</u> diagnosis, including fourth and fifth digits if present. (Do <u>not</u> enter decimal point.)</p> <p>The following services are exempt from diagnosis descriptions and codes when they are the <u>only</u> services billed on the claim:</p> <ol style="list-style-type: none"> 1. Anesthesia services 2. Assistant surgeon services 3. Medical supplies and materials (includes DME [except incontinence supplies]), hearing aids, orthotic and prosthetic appliances 4. Medical transportation 5. Pathology services (referenced in the CPT-4 book) 6. Radiology services (except: CAT scan, nuclear medicine, ultrasound, radiation therapy, and portable X-ray services, which <u>require</u> diagnosis codes).
21.B	<p>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. If applicable, enter all letters and/or numbers of the <u>secondary</u> ICD-9-CM code, including fourth and fifth digits if present. (Do <u>not</u> enter decimal point.)</p> <p>Note: Medi-Cal only accepts two diagnosis codes. Codes entered in Boxes 21.C – L will not be used for claims processing.</p>

Item Description

Note to Incontinence Supply Providers: Only the following ICD-9-CM codes will be accepted as the secondary diagnosis.

ICD-9-CM Code

307.6	788.34
307.7	788.35
787.6	788.36
788.30	788.37
788.31	788.38
788.32	788.39
788.33	

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** Not required by Medi-Cal.
C – L

22. **RESUBMISSION CODE/ORIGINAL REF. NO.** Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are:

Code Explanation

0	Under 65, does not have Medicare coverage
1 *	Benefits exhausted
2 *	Utilization committee denial or physician non-certification
3 *	No prior hospital stay
4 *	Facility denial
5 *	Non-eligible provider
6 *	Non-eligible recipient
7 *	Medicare benefits denied or cut short by Medicare intermediary
8 *	Non-covered services
9 *	PSRO denial
L *	Medi/Medi Charpentier: Benefit Limitations
R *	Medi/Medi Charpentier: Rates
T *	Medi/Medi Charpentier: Both Rates and Benefit Limitations

* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in this manual for additional information.

Item Description

23. **PRIOR AUTHORIZATION NUMBER.** For physician and podiatry services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

24.1 **CLAIM LINE.** Information for completing a claim line follows in Items 24A – 24J. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

Note: Do not enter data in the shaded area except as noted for Boxes 24A, C and D.

24A. **DATE(S) OF SERVICE.** In the unshaded area, enter the date the service was rendered in the “From” and “To” boxes in the six-digit, MMDDYY (Month, Day, Year) format; for example, April 2, 2013 = 040213. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

National Drug Code (NDC) for Physician-Administered Drugs: In the shaded area, enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). Refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual for more information.

Universal Product Number (UPN) for contracted disposable incontinence and medical supplies: In the shaded area, enter the appropriate UPN qualifier followed by the UPN.

The following is a list of UPN qualifiers. Claims for contracted disposable incontinence and medical supplies require the UPN qualifiers as published in the appropriate Part 2 manual.

Qualifier	Description	Number of Characters
HI	Health Care Industry Bar Code (HIBC)	6-18
EO	GTIN EAN/UCC	8
UP	Consumer Package Code U.P.C.	12
EN	European Article Number (EAN)	13
UK	U.P.C./EAN Shipping Container Code	14
ON	Customer Order Number	1-19

Item Description

24B. **PLACE OF SERVICE.** Enter one code from the list below indicating where the service was rendered:

<u>Code</u>	<u>Place of Service</u>
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF)
32	Nursing Facility (NF)
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment

Item Description

24B. **PLACE OF SERVICE (continued)**

<u>Code</u>	<u>Place of Service</u>
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

Note: If subacute care, specify the appropriate Place of Service and use modifier U2.

24C. **EMG.** Emergency or delay reason codes.

Delay Reason Code: If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim. (Refer to the *CMS-1500 Submission and Timeliness Instructions* section in this manual.)

Emergency Code: Enter an "X" when billing for emergency services, or the claim may be reduced or denied. Only one emergency indicator is allowed per claim, and must be placed in the unshaded, bottom portion of Box 24C. An Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist, dentist or pharmacist's statement, describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 24D. | <p>PROCEDURES, SERVICES OR SUPPLIES/MODIFIER.
Enter the applicable procedure code (HCPCS or CPT-4) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Medi-Cal accepts up to four modifiers** for a procedure on a single claim line. Enter modifiers in the boxes provided.</p> <p>** National Correct Coding Initiative (NCCI): Do not submit multiple NCCI-associated modifiers on the same claim line. The claim will be denied. Do not submit an NCCI-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted. (See the <i>Correct Coding Initiative: National</i> and <i>Modifiers: Approved List</i> sections in the appropriate Part 2 manual for important instructions.)</p> <p>Note: Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier UD in the modifier area of Box 24D. Section 340B drugs may be billed on the same claim as non-340B drugs.</p> |

Unit of Measure Qualifier/
Numeric Quantity

Claims for physician-administered drugs and contracted incontinence or disposable medical supplies may include a two-character unit of measure qualifier (F2 [International Unit], GR [gram], ML [milliliter] or UN [unit]) followed by a numeric quantity.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

On the *CMS-1500* claim, the unit of measure qualifier and numeric quantity combined are 12 characters long. The qualifier is the first two characters and the quantity is 10 digits as follows: Digits 1-7 are the whole number portion of the quantity. Digits 8-10 are the decimal portion and must be entered whether or not there is a decimal portion to be reported. (Decimal example: For a quantity of 124.54 milliliters enter ML0000124540.)

Products billed as “each,” “inches” or “yards” with a unit of measure that is a whole number (no decimal portion) are billed as follows:

“The unit of measure qualifier/numeric quantity number is entered on the claim in 12-character format with the first two characters being “UN” and the last three “000.” For example, one “ea” item would be entered on the claim as UN0000001000, 16 “yd” (per yard) items as UN0000016000, and 240 “inch” (per inch) items as UN0000240000.”

See the following “Physician-Administered Drugs” and “Incontinence and Disposable Medical Supplies” entries for more information.

Physician-Administered Drugs

If the item being billed is a physician-administered drug, enter in the shaded area above the procedure code the two-character unit of measure qualifier directly followed by the numeric quantity administered to the patient. Refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual for more information.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Incontinence and Disposable Medical Supplies

If the item being billed is an incontinence or disposable medical supply, enter the product’s HCPCS Level II code. (For codes see the *Incontinence Products* or *Medical Supply Products* sections of the Part 2 *Durable Medical Equipment [DME] and Medical Supplies* or *Pharmacy* manual). Enter the two-character unit of measure qualifier directly followed by the numeric quantity in the shaded area above the procedure code.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Medicare/Medi-Cal Recipients

Medicare non-covered services codes are listed in the Medicare non-covered services codes sections in this manual. Only those services listed in the Medicare non-covered sections may be billed directly to Medi-Cal. All others must be billed to Medicare first.

For a listing of approved CPT-4 and Medi-Cal-only modifier codes, refer to the *Modifiers: Approved List* section in the appropriate Part 2 manual.

To determine if a medical supply must be billed to Medicare prior to billing Medi-Cal, refer to the *Medical Supplies: Medicare Covered Services* section in the appropriate Part 2 manual. Those medical supplies listed in *Medical Supplies: Medicare Covered Services* section must be billed to Medicare prior to billing Medi-Cal.

Item Description

24E. **DIAGNOSIS POINTER.** As required by Medi-Cal.

24F. **CHARGES.** In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000, not 100). If an item is a taxable medical supply, include the applicable state and county sales tax.

Laboratory Charges

When billing “outside” laboratory work, enter the actual amount charged by the laboratory in Box 24F. Handling charges must be billed as a separate line item.

24G. **DAYS OR UNITS.** Enter the number of medical “visits” or procedures, surgical “lesions,” hours of “detention time,” units of anesthesia time, items or units of service, etc.

The field permits entries of up to 999. For entries greater than 999, carry the remaining value to the next claim line. For example, if the entry value is 1236, the first claim line should read, “999”; the second claim line should read, “237.” Both figures total the original value of “1236.”

Do not enter a decimal point (.). Therefore, a quantity of “1” entered anywhere in the field, or with leading zeroes, would be seen by the Medi-Cal system as “001” and a “10” entered anywhere in the field would be seen as “010.”

Billing for Time

Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “4”).

Item Description

24H. **EPSDT FAMILY PLAN.** Enter code “1” or “2” if the services rendered are related to family planning (FP). Enter code “3” if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

<u>Code</u>	<u>Description</u>
1	Family Planning/Sterilization (sterilization <i>Consent Form</i> must be attached to the claim if code 1 is entered)
2	Family Planning/Other
3	CHDP Screening Related

Refer to the *Family Planning* section of the appropriate Part 2 manual for further details.

24I. **ID QUALIFIER FOR RENDERING PROVIDER.** Not required by Medi-Cal.

24J. **RENDERING PROVIDER ID NUMBER.** Enter the NPI for a rendering provider (unshaded area), if the provider is billing under a group NPI. This applies to all services.

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Deleting Information:
Items 24A thru 24J

If an error has been made to specific billing information entered on Items 24A thru 24J, draw a line through the entire detail line using a blue or black ballpoint pen. Enter the correct billing information on another line.

Note: Do not “black-out” entire claim line. Deleted information may be used to determine previous payment.

24. A.	DATE(S) OF SERVICE					B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	PHYSICIAN OR SUPPLIER INFORMATION
	From	To	MM	DD	YY			PLACE OF SERVICE	EMD							
1	11	01	05			11		97810	A3		50.00	1		NPI	0123456789	
2	11	01	05			11		97810	A1		75.00	1		NPI	0123456789	
3														NPI		
4														NPI		
5														NPI		
6														NPI		

Figure 2. Sample of Deleted Information.

Item Description

24.2 – 24.6 **ADDITIONAL CLAIM LINES.** Follow instructions for each claim line.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 25. | FEDERAL TAX I.D. NUMBER. Not required by Medi-Cal. |
| 26. | PATIENT'S ACCOUNT NO. This is an optional field that will help providers to easily identify a recipient on a <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Enter the patient's control number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD) Completion</i> and <i>Remittance Advice Details (RAD)</i> examples sections in this manual. |
| 27. | ACCEPT ASSIGNMENT? Not required by Medi-Cal. |
| 28. | TOTAL CHARGE. In full dollar amount, enter the total for all services. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). |

<u>Item</u>	<u>Description</u>
29.	AMOUNT PAID. Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). <u>Do not enter Medicare payments in this box.</u> The Medicare payment amount will be calculated from the Medicare <i>Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)/Remittance Advice (RA)</i> when submitted with the claim.
30.	Rsvd for NUCC USE. Effective September 22, 2014, providers no longer complete this field.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 31. | <p>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only.</p> <p>An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.</p> |
| 32. | <p>SERVICE FACILITY LOCATION INFORMATION. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.</p> <p>Note: Not required for clinical laboratories when billing for their own services.</p> |
| 32a. | Enter the NPI of the facility where the services were rendered. |
| 32b. | Enter the Medi-Cal provider number for an atypical service facility. |

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 33. | <p>BILLING PROVIDER INFO AND PHONE NUMBER. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number.</p> <p>Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.</p> |
| 33a. | Enter the billing provider's NPI. |
| 33b. | Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider. |
| | <p>Note: Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.</p> |

Check Digits

For atypical providers, DHCS assigns a check digit to each provider to verify accurate input of the Medi-Cal provider number. The check digit is not a required item. However, including the check digit ensures that reimbursement for the claim is made to the correct provider. Providers should enter their check digit to the right of the Medi-Cal provider number in Box 32B. Providers who do not know their check digit should contact the Telephone Service Center (TSC) at 1-800-541-5555.

CMS-1500 VERSION 08/05 COMPLETION DIRECTIONS

For Use Through March 31, 2014

The 08/05 version of the *CMS-1500* is illustrated on the following page. This version is used for claims processing through March 31, 2014. After that date, Medi-Cal accepts claims for processing only on the *CMS-1500* version 02/12.

This older claim version is missing a field that identifies whether an ICD-9-CM code or ICD-10-CM code is being submitted. In 2014, national claim completion standards changed to require identification of the international classification of diseases version entered on the claim.

Additional Claim Completion Help

For additional billing information, refer to the *CMS-1500 Special Billing Instructions*, *CMS-1500 Submission and Timeliness Instructions* and the *CMS-1500 Tips for Billing* sections in this manual.

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>																											
HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>																											
<small>PICA</small>										<small>PICA</small>																	
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) MEDI-CAL ID NUMBER																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT'S COMPLETE NAME						3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> SEX <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) MOTHER'S NAME FOR NEWBORN																		
5. PATIENT'S ADDRESS (No., Street) PATIENT'S COMPLETE ADDRESS						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)																		
CITY PATIENT'S CITY			STATE ST			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE															
ZIP CODE PATIENT'S ZIP			TELEPHONE (Include Area Code) (PATIENT'S PHONE			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			CITY			STATE															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX <input type="checkbox"/>																		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME																		
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE CARRIER CODE																		
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d</i> OTHER COVERAGE/AMOUNT																		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED NA DATE NA						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																					
14. DATE OF CURRENT ONSET DATE MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY FROM NA TO NA																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE NAME OF REFERRING PROVIDER						17a. <input type="checkbox"/> <input type="checkbox"/>			17b. NPI NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM FROM DOS TO THRU DOS															
19. RESERVED FOR LOCAL USE																											
ADDITIONAL JUSTIFICATION PLACED HERE																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)																											
1. PRIMARY ICD-9 CODE			3. NA			22. MEDICAID RESUBMISSION CODE RESUBMIT CODE			ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER TAR CONTROL NUMBER															
2. SECONDARY ICD-9 CODE			4. NA			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #									
1	QUALIFIER + NDC or UPN		DELAY POS EMER		UNIT QUALIFIER AND QUANTITY		PROC MODIFIERS		SERVICE CHARGES		Q U A N T I T Y		F P N P I		NON-NPI NUMBER												
2	DOS FROM		DOS THRU		CODE		NPI		NPI		NPI		NPI		NPI												
3	DOS FROM		DOS THRU		CODE		NPI		NPI		NPI		NPI		NPI												
4	DOS FROM		DOS THRU		CODE		NPI		NPI		NPI		NPI		NPI												
5	DOS FROM		DOS THRU		CODE		NPI		NPI		NPI		NPI		NPI												
6	DOS FROM		DOS THRU		CODE		NPI		NPI		NPI		NPI		NPI												
25. FEDERAL TAX I.D. NUMBER				SSN EIN				26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NUMBER				27. ACCEPT ASSIGNMENT? (If or govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ TOTAL CHARGES				29. AMOUNT PAID \$ TOTAL DEDUCTIONS				30. BALANCE DUE \$ NET BILLED			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE OF PROVIDER OR PERSON AUTHORIZED SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION NAME AND ADDRESS OF SERVICE FACILITY a. FACILITY NPI b. NON-NPI NUMBER						33. BILLING PROVIDER INFO & PH # (PHONE NUMBER) BILLER ADDRESS a. BILLER NPI b. NON-NPI NUMBER															
NUCC Instruction Manual available at: www.nucc.org												APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)															

Figure 3. CMS-1500 version 08/05: Medi-Cal-Required Fields.

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *CMS-1500* on the previous page and are unique to Medi-Cal. All items must be completed unless otherwise noted in these instructions.

Note: Items described as “Not required by Medi-Cal” (NA) may be completed for other payers but are not recognized by the Medi-Cal claims processing system.

UNDESIGNATED WHITE SPACE. Do not type in the top one inch of the *CMS-1500* claim form, because this area is reserved for fiscal intermediary use.

Item Description

1. **MEDICAID/MEDICARE/OTHER ID.** If the claim is a Medi-Cal claim, enter an “X” in the Medicaid box. If submitting a Medicare/Medi-Cal crossover claim, use a copy of the original *CMS-1500* billed to Medicare and enter an “X” in both the *Medicaid* and *Medicare* boxes.

Note: For more information about crossover claims, refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.

1A. **INSURED’S ID NUMBER.** Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

Newborn Infant

When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother’s ID number in this field. (For more information, see Item 2 on a following page.)

<u>Item</u>	<u>Description</u>
2.	<p>PATIENT'S NAME. Enter the recipient's last name, first name, and middle initial (if known). Avoid nicknames or aliases.</p> <p>Newborn Infant</p> <p>When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 2. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: Jones Baby Girl). If billing for newborn infants from a multiple birth, each newborn also must be designated by a number or letter (example: Jones Baby Girl Twin A). Providers may also wish to use the <i>Patient's Account No.</i> field (Box 26) to enter Twin A (or B). This is not a required field, and only for provider convenience. This field is repeated in all payment information (such as the <i>Remittance Advice Details [RAD]</i>), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.</p> <p>Enter the infant's sex and date of birth in Box 3, and check the <i>Child</i> box in Box 6 (<i>Patient's Relationship to Insured</i>). Enter the mother's name in Box 4 (<i>Insured's Name</i>).</p> <p>Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number. To facilitate reimbursement for infants (including twins) using the mother's ID number, enter NEWBORN INFANT USING MOTHER'S ID in the <i>Reserved for Local Use</i> field (Box 19) or NEWBORN INFANT USING MOTHER'S ID (TWIN A) or (TWIN B).</p>
3.	<p>PATIENT'S BIRTH DATE/SEX. Enter the recipient's date of birth in six-digit MMDDYY (Month, Day, Year) format (for example, September 1, 1963 = 090163). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns, see Item 2.)</p> <p>If the recipient is 100 years or older, enter the recipient's age and the full <u>four</u>-digit year of birth in the <i>Reserved for Local Use</i> field (Box 19).</p> <p>Enter an "X" in the "M" or "F" box. Obtain the sex indicator from the BIC. (For newborns, see Item 2.)</p>
4.	<p>INSURED'S NAME. Not required by Medi-Cal, except when billing for an infant using the mother's ID. Enter the mother's name in this field when billing for the infant.</p>

<u>Item</u>	<u>Description</u>
5.	PATIENT'S ADDRESS/TELEPHONE. Enter recipient's complete address and telephone number.
6.	PATIENT RELATIONSHIP TO INSURED. Not required by Medi-Cal. This field may be used when billing for an infant using the mother's ID by checking the <i>Child</i> box.
7.	INSURED'S ADDRESS. Not required by Medi-Cal.
8.	PATIENT STATUS. Not required by Medi-Cal.
9.	OTHER INSURED'S NAME. Not required by Medi-Cal.
9A.	OTHER INSURED'S POLICY OR GROUP NUMBER. Not required by Medi-Cal.
9B.	OTHER INSURED'S DATE OF BIRTH. Not required by Medi-Cal.
9C.	EMPLOYER'S NAME OR SCHOOL NAME. Not required by Medi-Cal.
9D.	INSURANCE PLAN NAME OR PROGRAM NAME. Not required by Medi-Cal.

<u>Item</u>	<u>Description</u>
10.	IS PATIENT'S CONDITION RELATED TO:
10A.	EMPLOYMENT. Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the <i>Date of Current Illness, Injury or Pregnancy</i> field (Box 14).
10B.	AUTO ACCIDENT/PLACE. Not required by Medi-Cal.
10C.	OTHER ACCIDENT. Not required by Medi-Cal.
10D.	RESERVED FOR LOCAL USE (Share of Cost). Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). For more information about SOC, refer to the <i>Share of Cost (SOC)</i> section in the Part 1 manual. Also refer to the <i>Share of Cost (SOC): CMS-1500</i> section or the <i>Share of Cost (SOC): 30-1 for Pharmacy</i> section in the appropriate Part 2 manual.
11.	INSURED'S POLICY GROUP OR FECA NUMBER. Not required by Medi-Cal.
11A.	INSURED'S DATE OF BIRTH/SEX. Not required by Medi-Cal.
11B.	EMPLOYER'S NAME OR SCHOOL NAME. Not required by Medi-Cal.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 11C. | INSURANCE PLAN NAME OR PROGRAM NAME. For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code. |
| 11D. | IS THERE ANOTHER HEALTH BENEFIT PLAN. Enter an "X" in the Yes box if recipient has Other Health Coverage (OHC). OHC includes insurance carriers, Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) who provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered Other Health Coverage. |

Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual.

If the Other Health Coverage has paid, enter the amount in the upper right side of this field as shown in *Figure 4* on a following page in this section. Do not enter a decimal point (.) or dollar sign (\$).

<u>Item</u>	<u>Description</u>
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Not required by Medi-Cal.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP). Enter the date of onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP).
15.	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE. Not required by Medi-Cal.
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION. Not required by Medi-Cal.

<u>Item</u>	<u>Description</u>
17.	<p>NAME OF REFERRING PROVIDER OR OTHER SOURCE. Enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the non-physician medical practitioner must be entered.</p> <p>Note: Providers billing lab service for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A or NF-B as the referring provider.</p>
17A.	<p>UNLABELED. Not required by Medi-Cal.</p>
17B.	<p>NPI. Enter the National Provider Identifier (NPI).</p> <p>Boxes 17 and 17B <u>must</u> be completed by the following providers:</p> <ul style="list-style-type: none"> • Clinical laboratory (services billed by laboratory) • Durable Medical Equipment (DME) and medical supply • Hearing aid dispenser • Orthotist • Prosthetist • Nurse anesthetist • Occupational therapist • Physical therapist • Podiatrist (when services are rendered in a Skilled Nursing Facility [NF A or B]) • Portable X-ray • Radiologist • Speech pathologist • Audiologist • Pharmacies

Item Description

Boxes 17 and 17B (continued)

In-State Referring Provider

A Universal Provider Information Number (UPIN) is not allowed.

Out-of-State Referring Provider

Claims must include a referring provider number using the referring provider's individual (not group) number. A license number or UPIN is not allowed.

Dental Referring Providers: In-State

Claims must include a referring provider number . Add the prefix "DDS" to the referring provider license number on the claim. A provider number or UPIN is not allowed.

Dental Referring Providers: Out-of-State

Claims must include a referring provider number. Add the prefix "DEN" to the referring provider license number on the claim. UPINs are not allowed.

A non-physician medical practitioner authorized to refer with the physician's provider number should include the number of the supervising physician on the referral. The billing provider also should enter the number of the supervising physician. Claims with a non-physician medical practitioner number will not be reimbursed.

When a billing provider receives a *Resubmission Turnaround Document* (RTD) or denial due to an invalid referring provider number, the referring provider should be contacted to verify the status of the provider number.

A physician's assistant (and other non-physician practitioners authorized to refer with the physician's number) should include the provider number of the supervising physician on the referral. The billing provider should enter the provider number of the supervising physician. Claims with a Non-physician Medical Practitioner (NMP) license number will not be reimbursed.

Note: Referring providers who would like to participate in the Medi-Cal program may contact the Telephone Service Center (TSC) at 1-800-541-5555.

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 18. | HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank. |
| 19. | RESERVED FOR LOCAL USE. Use this area for procedures that require additional information or justification. For specific "By Report" attachment requirements, refer to the <i>CMS-1500 Special Billing Instructions</i> section of this manual. |

Attachments

Claims for "By Report" codes, complicated procedures (modifier 22), unlisted services and anesthesia time require attachments. This information may also be entered in the *Reserved for Local Use* field (Box 19) if space permits.

Reports are not required for routine procedures. Non-reimbursable CPT-4 codes are listed in the *TAR and Non-Benefit List: Codes 10000 – 99999* sections of the appropriate Part 2 manual. Refer to "Attachments" in the *CMS-1500 Special Billing Instructions* section in this manual, the CPT-4 book or in the appropriate policy sections for details.

Note: Please do not staple attachments.

Item Description

20. **OUTSIDE LAB?** If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X."
"Outside" laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank if not applicable.

OUTSIDE LAB \$ CHARGES. Not required by Medi-Cal.

21.1 **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis, including fourth and fifth digits if present. (Do not enter decimal point.)

The following services are exempt from diagnosis descriptions and codes when they are the only services billed on the claim:

1. Anesthesia services
2. Assistant surgeon services
3. Medical supplies and materials (includes DME [except incontinence supplies]), hearing aids, orthotic and prosthetic appliances
4. Medical transportation
5. Pathology services (referenced in the CPT-4 book)
6. Radiology services (except: CAT scan, nuclear medicine, ultrasound, radiation therapy, and portable X-ray services, which require diagnosis codes).

21.2 **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code, including fourth and fifth digits if present. (Do not enter decimal point.)

Note: Medi-Cal only accepts two diagnosis codes. Codes entered in Box 21.3 and 21.4 will not be used for claims processing.

Note to Incontinence Supply Providers: Only the following ICD-9-CM codes will be accepted as the secondary diagnosis.

ICD-9-CM Code

307.6	788.34
307.7	788.35
787.6	788.36
788.30	788.37
788.31	788.38
788.32	788.39
788.33	

- | <u>Item</u> | <u>Description</u> |
|-------------|---|
| 21.3 | DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Not required by Medi-Cal. |
| 21.4 | DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Not required by Medi-Cal. |
| 22. | MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are: |

<u>Code</u>	<u>Explanation</u>
0	Under 65, does not have Medicare coverage
1 *	Benefits exhausted
2 *	Utilization committee denial or physician non-certification
3 *	No prior hospital stay
4 *	Facility denial
5 *	Non-eligible provider
6 *	Non-eligible recipient
7 *	Medicare benefits denied or cut short by Medicare intermediary
8 *	Non-covered services
9 *	PSRO denial
L *	Medi/Medi Charpentier: Benefit Limitations
R *	Medi/Medi Charpentier: Rates
T *	Medi/Medi Charpentier: Both Rates and Benefit Limitations

* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in this manual for additional information.

Item Description

23. **PRIOR AUTHORIZATION NUMBER.** For physician and podiatry services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

24.1 **CLAIM LINE.** Information for completing a claim line follows in Items 24A – 24J. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

Note: Do not enter data in the shaded area except as noted for Boxes 24A, C and D.

24A. **DATE(S) OF SERVICE.** In the unshaded area, enter the date the service was rendered in the “From” and “To” boxes in the six-digit, MMDDYY (Month, Day, Year) format; for example, April 2, 2009 = 040209. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

National Drug Code (NDC) for Physician-Administered Drugs: In the shaded area, enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). Refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual for more information.

Universal Product Number (UPN) for contracted disposable incontinence and medical supplies: In the shaded area, enter the appropriate UPN qualifier followed by the UPN.

The following is a list of UPN qualifiers. Claims for contracted disposable incontinence and medical supplies require the UPN qualifiers as published in the appropriate Part 2 manual.

<u>Qualifier</u>	<u>Description</u>	<u>Number of Characters</u>
HI	Health Care Industry Bar Code (HIBC)	6-18
EO	GTIN EAN/UCC	8
UP	Consumer Package Code U.P.C.	12
EN	European Article Number (EAN)	13
UK	U.P.C./EAN Shipping Container Code	14
ON	Customer Order Number	1-19

Item Description

24B. **PLACE OF SERVICE.** Enter one code from the list below indicating where the service was rendered:

<u>Code</u>	<u>Place of Service</u>
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
13	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic
26	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF)
33	Nursing Facility (NF)
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
43	Ambulance (Air or Water)
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
56	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment

Item Description

24B. **PLACE OF SERVICE (continued)**

<u>Code</u>	<u>Place of Service</u>
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other

Note: If subacute care, specify the appropriate Place of Service and use modifier U2.

24C. **EMG.** Emergency or delay reason codes.

Delay Reason Code: If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim. (Refer to the *CMS-1500 Submission and Timeliness Instructions* section in this manual.)

Emergency Code: Enter an "X" when billing for emergency services, or the claim may be reduced or denied. Only one emergency indicator is allowed per claim, and must be placed in the unshaded, bottom portion of Box 24C. An Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable X-ray providers, psychiatrists and out-of-state providers. These statements must be signed and dated by the provider and must be supported by a physician, podiatrist, dentist or pharmacist's statement, describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 24D. | <p>PROCEDURES, SERVICES OR SUPPLIES/MODIFIER.
Enter the applicable procedure code (HCPCS or CPT-4) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Medi-Cal accepts up to four modifiers** for a procedure on a single claim line. Enter modifiers in the boxes provided.</p> <p>** National Correct Coding Initiative (NCCI): Do not submit multiple NCCI-associated modifiers on the same claim line. The claim will be denied. Do not submit an NCCI-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted. (See the <i>Correct Coding Initiative: National and Modifiers: Approved List</i> sections in the appropriate Part 2 manual for important instructions.)</p> <p>Note: Providers billing for physician-administered drugs subject to the federally established 340B Drug Pricing Program must include the modifier UD in the modifier area of Box 24D. Section 340B drugs may be billed on the same claim as non-340B drugs.</p> |

Unit of Measure Qualifier/
Numeric Quantity

Claims for physician-administered drugs and contracted incontinence or disposable medical supplies may include a two-character unit of measure qualifier (F2 [International Unit], GR [gram], ML [milliliter] or UN [unit]) followed by a numeric quantity.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

On the *CMS-1500* claim, the unit of measure qualifier and numeric quantity combined are 12 characters long. The qualifier is the first two characters and the quantity is 10 digits as follows: Digits 1-7 are the whole number portion of the quantity. Digits 8-10 are the decimal portion and must be entered whether or not there is a decimal portion to be reported. (Decimal example: For a quantity of 124.54 milliliters enter ML0000124540.)

Products billed as “each,” “inches” or “yards” with a unit of measure that is a whole number (no decimal portion) are billed as follows:

“The unit of measure qualifier/numeric quantity number is entered on the claim in 12-character format with the first two characters being “UN” and the last three “000.” For example, one “ea” item would be entered on the claim as UN0000001000, 16 “yd” (per yard) items as UN0000016000, and 240 “inch” (per inch) items as UN0000240000.”

See the following “Physician-Administered Drugs” and “Incontinence and Disposable Medical Supplies” entries for more information.

Physician-Administered Drugs

If the item being billed is a physician-administered drug, enter in the shaded area above the procedure code the two-character unit of measure qualifier directly followed by the numeric quantity administered to the patient. Refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* section in this manual for more information.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Incontinence and Disposable Medical Supplies

If the item being billed is an incontinence or disposable medical supply, enter the product’s HCPCS Level II code. (For codes see the *Incontinence Products* or *Medical Supply Products* sections of the Part 2 *Durable Medical Equipment [DME] and Medical Supplies* or *Pharmacy* manual). Enter the two-character unit of measure qualifier directly followed by the numeric quantity in the shaded area above the procedure code.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Medicare/Medi-Cal Recipients

Medicare non-covered services codes are listed in the Medicare non-covered services codes sections in this manual. Only those services listed in the Medicare non-covered sections may be billed directly to Medi-Cal. All others must be billed to Medicare first.

For a listing of approved CPT-4 and Medi-Cal-only modifier codes, refer to the *Modifiers: Approved List* section in the appropriate Part 2 manual.

To determine if a medical supply must be billed to Medicare prior to billing Medi-Cal, refer to the *Medical Supplies: Medicare Covered Services* section in the appropriate Part 2 manual. Those medical supplies listed in *Medical Supplies: Medicare Covered Services* section must be billed to Medicare prior to billing Medi-Cal.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 24E. | DIAGNOSIS POINTER. As required by Medi-Cal. |
| 24F. | CHARGES. In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000, not 100). If an item is a taxable medical supply, include the applicable state and county sales tax. |

Laboratory Charges

When billing “outside” laboratory work, enter the actual amount charged by the laboratory in Box 24F. Handling charges must be billed as a separate line item.

- | | |
|------|--|
| 24G. | DAYS OR UNITS. Enter the number of medical “visits” or procedures, surgical “lesions,” hours of “detention time,” units of anesthesia time, items or units of service, etc. |
|------|--|

The field permits entries of up to 999. For entries greater than 999, carry the remaining value to the next claim line. For example, if the entry value is 1236, the first claim line should read, “999”; the second claim line should read, “237.” Both figures total the original value of “1236.”

Do not enter a decimal point (.). Therefore, a quantity of “1” entered anywhere in the field, or with leading zeroes, would be seen by the Medi-Cal system as “001” and a “10” entered anywhere in the field would be seen as “010.”

Billing for Time

Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “4”).

Item Description

24H. **EPSDT FAMILY PLAN.** Enter code “1” or “2” if the services rendered are related to family planning (FP). Enter code “3” if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

<u>Code</u>	<u>Description</u>
1	Family Planning/Sterilization (sterilization <i>Consent Form</i> must be attached to the claim if code 1 is entered)
2	Family Planning/Other
3	CHDP Screening Related

Refer to the *Family Planning* section of the appropriate Part 2 manual for further details.

24I. **ID QUALIFIER FOR RENDERING PROVIDER.** Not required by Medi-Cal.

24J. **RENDERING PROVIDER ID NUMBER.** Enter the NPI for a rendering provider (unshaded area), if the provider is billing under a group NPI.

The rendering provider instructions apply to services rendered by the following providers:

- | | |
|-------------------------|--------------------------|
| Acupuncturists | Physicians |
| Chiropractors | Podiatrists |
| Licensed audiologists | Portable X-ray providers |
| Occupational therapists | Prosthetists |
| Ophthalmologists | Psychologists |
| Orthotists | Radiology labs |
| Physical therapists | Speech pathologists |
| Physician groups | |

Deleting Information:
Items 24A thru 24J

If an error has been made to specific billing information entered on Items 24A thru 24J, draw a line through the entire detail line using a blue or black ballpoint pen. Enter the correct billing information on another line.

Note: Do not “black-out” entire claim line. Deleted information may be used to determine previous payment.

24. A	DATE(S) OF SERVICE					B PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS POINTER	F \$ CHARGES	G QNTY OR UNTS	H UNIT PRY Pwr	I ID QUAL	J. RENDERING PROVIDER ID #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER												
1	11	01	05			11		97810	A3		50.00	1		NPI	0123456789	
2	11	01	05			11		97810	A1		75.00	1		NPI	0123456789	
3														NPI		
4														NPI		
5														NPI		
6														NPI		

Figure 4. Sample of Deleted Information.

Item Description

24.2 – 24.6 **ADDITIONAL CLAIM LINES.** Follow instructions for each claim line.

<u>Item</u>	<u>Description</u>
25.	FEDERAL TAX I.D. NUMBER. Not required by Medi-Cal.
26.	PATIENT'S ACCOUNT NO. This is an optional field that will help providers to easily identify a recipient on a <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Enter the patient's control number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD) Completion</i> and <i>Remittance Advice Details (RAD)</i> examples sections in this manual.
27.	ACCEPT ASSIGNMENT? Not required by Medi-Cal.
28.	TOTAL CHARGE. In full dollar amount, enter the total for all services. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100).

<u>Item</u>	<u>Description</u>									
29.	<p>AMOUNT PAID. Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100). <u>Do not enter Medicare payments in this box.</u> The Medicare payment amount will be calculated from the Medicare <i>Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)/Remittance Advice (RA)</i> when submitted with the claim.</p>									
30.	<p>BALANCE DUE. Enter the difference between <i>Total Charges</i> and <i>Amount Paid</i>. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (e.g., if billing for \$100, enter 10000 not 100).</p> <table border="0" style="margin-left: 40px;"> <tr> <td></td> <td style="text-align: right;">Total Charges</td> <td style="text-align: right;">Box 28</td> </tr> <tr> <td style="text-align: right;">(minus) –</td> <td style="text-align: right;"><u>Amount Paid</u></td> <td style="text-align: right;"><u>Box 29</u></td> </tr> <tr> <td></td> <td style="text-align: right;">Balance Due</td> <td style="text-align: right;">Box 30</td> </tr> </table>		Total Charges	Box 28	(minus) –	<u>Amount Paid</u>	<u>Box 29</u>		Balance Due	Box 30
	Total Charges	Box 28								
(minus) –	<u>Amount Paid</u>	<u>Box 29</u>								
	Balance Due	Box 30								

<u>Item</u>	<u>Description</u>
31.	<p>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only.</p> <p>An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.</p>
32.	<p>SERVICE FACILITY LOCATION INFORMATION. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.</p> <p>Note: Not required for clinical laboratories when billing for their own services.</p>
32A.	Enter the NPI of the facility where the services were rendered.
32B.	Enter the Medi-Cal provider number for an atypical service facility.

- | <u>Item</u> | <u>Description</u> |
|-------------|--|
| 33. | <p>BILLING PROVIDER INFO AND PHONE NUMBER. Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number.</p> <p>Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.</p> |
| 33A. | Enter the billing provider's NPI. |
| 33B. | <p>Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.</p> <p>Note: Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.</p> |

Check Digits

For atypical providers, DHCS assigns a check digit to each provider to verify accurate input of the Medi-Cal provider number. The check digit is not a required item. However, including the check digit ensures that reimbursement for the claim is made to the correct provider. Providers should enter their check digit to the right of the Medi-Cal provider number in Box 32B. Providers who do not know their check digit should contact the Telephone Service Center (TSC) at 1-800-541-5555.