CMS-1500 Billing Guide for PROMISe™ Certified Registered Nurse Anesthetists (CRNAs)

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:

- **Certified Registered Nurse Anesthetist (CRNA) – Provider Type 32**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:
    - **M** – Indicates that the claim block must be completed.
    - **A** – Indicates that the claim block must be completed, if applicable.
    - **O** – Indicates that the claim block is optional.
    - **LB** – Indicates that the claim block should be left blank.
    - ***** – Indicates special instruction for block completion.
- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

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IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24F ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24F, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is thirty-five dollars, enter:

24F	
$CHARGES	
35	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

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You must follow these instructions to complete the CMS-1500 claim form when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to DHS.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	O	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.
3	Patient's Birthdate and Sex	O	Enter the patient's date of birth using an 8-digit MM/DD/CCYY (month, day, century, and year) format (e.g., 02/15/1978) and indicate the patient's gender by placing an X in the appropriate box.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.

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Block No.	Block Name	Block Code	Notes
8	Reserved for NUCC Use	LB	Do not complete this block.
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy or Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a–d. Enter the policy number <u>and</u> the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Reserved for NUCC Use	LB	Do not complete this block.
9c	Reserved for NUCC Use	LB	Do not complete this block.
9d	Insurance Plan Name or Program Name	A	Enter the other insured's insurance plan name or program name.
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's 2-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for Pennsylvania).

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Block No.	Block Name	Block Code	Notes
10d	Claim Codes (Designated by NUCC)	O	It is optional to enter the nine-digit social security number of the policyholder if the policyholder is not the beneficiary.
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The beneficiary's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an eight-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) **Note:** Please refer to Section 6 of the PA PROMIS*e*™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.

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Block No.	Block Name	Block Code	Notes
14	Date of Current Illness, Injury or Pregnancy (LMP)	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).
15	Other Date	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Provider or Other Source	A	Enter the name and degree of the referring or prescribing practitioner, when applicable.
17a	I.D. Number of Referring Provider	A	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number **G2** = 13-digit Provider ID number (Legacy Number) In the second portion, enter the **license number** of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456). If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.
17b	NPI #	M	Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source.
18	Hospitalization	A	Complete only if the patient was hospitalized in an

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Block No.	Block Name	Block Code	Notes
	Dates Related to Current Services		inpatient setting. Enter the date of admission and the date of discharge in an 8-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).
19	Additional Claim Information (Designated by NUCC)	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**", followed by a two-digit number (i.e., **AT05**). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**", indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form MA 539 . When using "**AT10**", indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form MA 538 . Attachment Type Code "**AT99**" indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary's number on the top left-hand corner of the page (i.e., Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's beneficiary number. On the remarks sheet, include the mother's full name, date of birth, and social security number.). If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook. *For additional information on completing CMS-1500 claim form adjustments, please refer to Section 2.10 –*

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Block No.	Block Name	Block Code	Notes
			Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook. **Qualified Small Businesses** Qualified small businesses must <u>always</u> enter the following message in Block 19 (Additional Claim Information (Designated by NUCC))) of the CMS-1500, in addition to any applicable attachment type codes: "(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32."
*** Note:** If the patient has coverage through Medicare Part B and MA, this claim may automatically cross over to MA for payment of any applicable deductible and/or co-insurance amounts. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter AT05 in Block 19 and <u>attach the Explanation of Medicare Benefits to the claim.</u> Please refer to MA 539 for additional information. Do not show any amount in Block 24K. See MA Bulletin 99-94-07 for more details.		
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	The ICD indicator (ICD Ind) is required. If a valid "9" or "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete. For dates of service **prior** to October 1, 2015, enter the most specific ICD-9-CM code (indicator "9"); **OR** for dates of service **on or after** October 1, 2015, enter the ICD-10-CM code (indicator "0") that describes the diagnosis. The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.
22	Resubmission Code	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a

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Block No.	Block Name	Block Code	Notes
			previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the two-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Date(s) of Service	M/M	Enter the applicable date(s) of service. If billing for a service that was provided on one day only, complete either the **From** or the **To** column (but not both.) If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an 8-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.
24b	Place of Service	M	Enter the 2-digit place of service code that indicates where the service was performed. **11 –** Office (Dentist Only) **21** – Inpatient **22** – Outpatient Hospital **23** – Emergency Room **24** – Ambulatory Surgical Center (ASC)/ Hospital Short Procedure Unit
24c	EMG	A	Enter **1** if the service provided was in response to an emergency, **2** if urgent. Otherwise, leave this item blank.
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/M/A AAA	List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. When billing a Primary code with additional related (add-on) codes, the Primary code and the additional add-on code(s) must appear on the same claim. The Primary code **MUST** appear on the claim **first** preceding the add-on

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Block No.	Block Name	Block Code	Notes
			codes, regardless of where the primary code appears on the claim. **Note: Failure to follow this Billing procedure will result in the denial of your claim on edit 5529 "Related Procedures Must be Billed Together", 5535 "Primary Code Must be Billed Before Add-on Code", or 5536 "Primary Must be Billed Before Add-on Code (Different)".** In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to three additional informational modifiers, when applicable. If no pricing modifier is required, enter up to four additional / informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.
24e	Diagnosis Pointer	M	This block may contain up to four letters. Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21. If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis. Note: The primary diagnosis pointer must be entered first.
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24g	Days or Units	M	Enter the number of units, services, or items provided.
24h	EPSDT/Family Planning	LB	Do not complete this block

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Block No.	Block Name	Block Code	Notes
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **G2** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	M	Enter the 10-digit NPI number of the rendering provider.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to ten alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect beneficiary number is listed.
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	A	If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. **Do not enter copay in this block.**
30	Reserved for NUCC Use	LB	Do not complete this block.
31	Signature of Physician or Supplier Including	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, except for abortions, if the provider authorizes its use and assumes responsibility for the information on the claim. If

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Block No.	Block Name	Block Code	Notes
	Degree or Credentials		submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004).
32	Name and Address of Facility Where Services Were Rendered	A/A	If the service(s) was provided in an inpatient hospital, hospital short procedure unit, or freestanding ambulatory surgical center, enter the name of the hospital and 9-digit provider identification and 4-digit service location of the facility. **Do not use slashes, hyphens, or spaces**.
32a		M	Enter the 10-digit NPI number of the service facility.
32b		M/A	Enter the 13-digit facility Provider ID number (Legacy #)
33	Billing Provider Info & Ph.#	A/A& M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)