# 1. CMS-1500 Claim Form Completion for PROMISe™ Mental Health & Substance Abuse Providers

**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 for Provider Type 11 (Mental Health/Substance Abuse), which includes:

- **Family Based Mental Health**
- **Mental Health Crisis Intervention**
- **Partial Psychiatric Hospitalization Facility**
- **Licensed Social Worker**
- **Licensed Clinical Social Worker**
- **Peer Specialist**

**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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**Ordering and Prescribing**

The Patient Protection and Affordable Care Act (ACA) added requirements for provider screening and enrollment, including a requirement that states require physicians and other practitioners who order or refer items or services for MA beneficiaries to enroll as MA providers. The Department of Health and Human Services regulation implementing this requirement can be found at 42 CFR § 455.410.

Claims submitted by the following provider types and specialties must include the NPI of the MA enrolled ordering or prescribing provider:

**NPI only included on the following specialties**:

**11-076 Peer Specialist**

**11–115 Family Based Mental Health**

Providers should check block 17, 17a, and 17b for further direction.

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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 or approved rate, without a decimal point. You must include the dollars and cents. If your usual charge or approved rate 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 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 Medical Assistance.

| BlockNo. | 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 eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) 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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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| 8 | Reserved for NUCCC 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 and 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 block. |
| 9c | Reserved for NUCC Use | LB | Do not complete 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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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| 10d | Claim Codes (Designated by NUCC) | A | Enter the 9-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 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.<br>Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes).<br>**Note:** Please refer to Section 6 of the PA PROMISe™ 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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| BlockNo. | 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.<br>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 | M<br><br>M<br><br>LB | **Partial Psychiatric Hospitalization Providers:**<br>Enter the name of the attending and/or supervising physician.<br><br>**Peer Specialist and Family Based Mental Health Providers:**<br>Enter the name of the MA enrolled ordering or prescribing provider.<br><br>**Mental Health Crisis Intervention Providers:**<br>This block is not required to be completed. |
| 17a | I.D. Number of Referring Provider | M<br><br>M<br><br>LB | **Partial Psychiatric Hospitalization Providers:**<br>Enter the 9-digit provider number and the 4-digit service location of the attending and/or supervising physician named in Block 17 (e.g., 1234567891234).<br><br>**Peer Specialist and Family Based Mental Health Providers:**<br>Enter the 9-digit provider number and the 4-digit service location of the ordering or prescribing provider named in Block 17 (e.g., 1234567891234).<br><br>**Mental Health Crisis Intervention Providers:** |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| | | | This block is not required to be completed. |
| 17b | NPI # | A | Enter the 10-digit National Provider Identifier number of the attending and/or supervising physician or ordering or prescribing provider named in block 17. |
| 18 | Hospitalization Dates Related to Current Services | M/A | **Peer Specialist and Family Based Mental Health Providers:**<br>Complete only if the patient was hospitalized in an inpatient setting. Enter the date in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).<br>**Note #1:** When billing for beneficiaries who receive Peer Specialist or Family Based Mental Health services during an inpatient admission, you must enter the admit and discharge date. Please reference OMHSAS Policy Clarifications ICM-04 and RC-01 for program specific guidelines.<br>**Note #2:** Peer Specialist and Family Based Mental Health providers must wait until the beneficiary is discharged into the community prior to submitting the claim for services rendered in an inpatient setting or a long term care facility. |
| 19 | Additional Claim Information (Designated by NUCC) | 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**).<br>Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,).<br>When using "**AT05**", indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form MA 539.<br>When using "**AT10**", indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment |

| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| | | | for Commercial Insurance for Providers" form MA 538.<br>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.).<br>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.<br>For a complete listing and description of Attachment Type Codes, refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.<br>*For additional information on completing CMS-1500 claim form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.* |
| | | A | **Qualified Small Businesses**<br>Qualified small businesses must always 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:<br>"**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**" |
| ***Note:** If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter | | | |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information. | | | |
| 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 "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete.<br>0 = ICD-10-CM code<br>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:<br>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).<br>2) When submitting a claim adjustment for a 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 | A | **Partial Psychiatric Hospitalization Providers:**<br>If applicable, enter the 10-digit prior authorization or program exception number.<br>Refer to Section 7 of the CMS-1500 Provider Handbook for additional information regarding prior authorization for your specific provider type. |
| | | LB | **Family Based Mental Health**, **Mental Health Crisis Intervention, and Peer Specialist Providers:**<br>Do not complete this block. |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| 24a | Date(s) of Service | M/M | Enter the applicable date(s) of service.<br><br>If billing for a service that was provided on one day only, complete either the **From** or the **To** column (but not both.).<br><br>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 eight-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.<br><br>**Note:** Peer Specialists must bill each date of service on a separate claim line. |
| 24b | Place of Service | M | Enter the two-digit place of service code that indicates where the service was performed.<br><br>**Partial Psychiatric Hospitalization Facility and Peer Specialist:**<br><br>Refer to the medical assistance outpatient fee schedule for applicable place of service code information. |
| | | M | **Family Based Mental Health and Mental Health Crisis Intervention providers:**<br><br>Refer to the Community Support Services Procedure Code Chart for place of service information.<br>Community-Support-Services-Procedure-Code-Chart.pdf (pa.gov) |
| 24c | EMG | A | **Partial Psychiatric Hospitalization Facility:**<br><br>Enter **1** if the service provided was in response to an emergency, **2** if urgent. Otherwise, leave this item blank. |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| | | LB | **Family Based Mental Health, Mental Health Crisis Intervention, and Peer Specialist providers:**<br>Do not complete this block. |
| 24d | Procedures, Services, or Supplies (CPT/HCPCS & Modifier) | M/AAAA | List the procedure code(s) for the service(s) being rendered and any applicable modifier(s).<br>In the first section of the block, enter the procedure code that describes the service provided.<br>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.<br>**Family Based Mental Health and Mental Health Crisis Intervention providers:**<br>Refer to the Community Support Services Procedure Code Chart for procedure code/modifier information.<br>Community-Support-Services-Procedure-Code-Chart.pdf (pa.gov) |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| 24e | Diagnosis Pointer | M | This block may contain up to four letters.<br><br>Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21.<br><br>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.<br><br>**Note:** The primary diagnosis pointer must be entered first. |
| 24f | $Charges | M | **Partial Psychiatric Hospitalization and Peer Specialists:**<br><br>Enter your usual charge to the general public for the service(s) provided. For example, if your usual charge is thirty-five dollars, enter **3500**.<br><br>If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. |
| | | M | **Family Based Mental Health and Mental Health Crisis Intervention:**<br><br>Enter your approved rate for the service(s) provided. For example, if your approved rate is thirty-five dollars, enter **3500**.<br><br>If billing for multiple units of service, multiply your approved rate by the number of units billed and enter that amount.<br><br>**Note:** Although usual charge is reflective of the whole rate, only the federal portion is received through Medical Assistance. The state portion of the rate is required to be billed and paid by the County prior to billing Medical Assistance. |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| 24g | Days or Units | M | Enter the number of units, services, or items provided. |
| 24h | EPSDT/Family Planning | LB | Do not complete this block. |
| 24i | ID Qualifier | A | Enter the two-digit ID Qualifier:<br>**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).<br>**Note**: Only one rendering provider per claim form. |
| 24j (b) | NPI | A | 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 10 alpha, numeric, or alpha-numeric 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. |

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| BlockNo. | Block Name | Block Code | Notes |
|---|---|---|---|
| 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 Degree or Credentials | M/M | This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, if the provider authorizes its use and assumes responsibility for the information on the claim. If 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).<br>Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004). |
| 32 | Service Facility Location Information | LB | Do not complete this block. |
| 32a | | LB | Do not complete this block. |
| 32b | | LB | Do not complete this block. |
| 33 | Billing Provider Info & Ph.# | A/A& M/M | Enter the billing provider's name, address, and telephone number<br>**Do not use slashes, hyphens, or spaces.**<br>**Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office. |
| 33a | NPI# | M | Enter the 10-digit NPI number of the billing provider. |
| 33b | | M/A | Enter the 13-digit Group/Billing Provider ID number (Legacy #) |

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