CMS-1500 Billing Guide for PROMISe™ Employment Competitive 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:

- **Employment Competitive – Provider Type 53**

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 negotiated rate, without a decimal point. You must include the dollars and cents. If your negotiated rate is fifteen dollars, enter:

24F	
$CHARGES	
15	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 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	LB	Do not complete this block.
5	Patient's Address	LB	Do not complete this block.
6	Patient's Relationship to Insured	LB	Do not complete this block.
7	Insured's Address	LB	Do not complete this block.
8	Reserved for NUCC Use	LB	Do not complete this block.
9	Other Insured's Name	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
9a	Other Insured's Policy or Group Number	LB	Do not complete this block.
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	LB	Do not complete this block.
10a-10c	Is Patient's Condition Related To:	LB	Do not complete this block.
10d	Claim Codes (Designated by NUCC)	LB	Do not complete this block.
11	Insured's Policy Group or FECA Number	LB	Do not complete this block.
11a	Insured's Date of Birth and Sex	LB	Do not complete this block.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	LB	Do not complete this block.
11d	Is There Another Health Benefit Plan?	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
12	Patient's or Authorized Person's Signature and Date	M/M	The patient's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) **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	LB	Do not complete this block.
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.

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Block No.	Block Name	Block Code	Notes
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.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Additional Claim Information (Designated by NUCC)	A	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 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*

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Block No.	Block Name	Block Code	Notes
		A	**Qualified Small Businesses** 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: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
20	Outside Lab	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	LB	Do not complete this block.
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 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	If applicable, enter the 10-digit prior authorization number. Refer to Section 7 of the CMS-1500 Claim Form Provider Handbook for additional information regarding prior authorization for your specific provider type.
24a	Date(s) of Service	M/M	Enter the applicable date(s) of service.

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Block No.	Block Name	Block Code	Notes
24b	Place of Service	M	Enter the two-digit place of service code that indicates where the service was performed. **99** – Other (Community)
24c	EMG	LB	Do not complete this block**.**
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	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. 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. *For compensable procedure code modifier combinations, please refer to the PA* PROMISe™ *fee schedule accessible via the DPW Internet site.*
24e	Diagnosis Pointer	LB	Do not complete this block**.**
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.

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Block No.	Block Name	Block Code	Notes
24h	EPSDT/Family Planning	A	Enter the two-digit Visit Code, if applicable. Visit Codes are especially important if providing services that do not require copay (i.e., for a pregnant beneficiary or long term care resident.) *For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
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	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 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.

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Block No.	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, except for abortions, 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). 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 **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		A	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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