



# InstaGuide to the

# 1500

# HEALTH INSURANCE CLAIM FORM

- **National Uniform Claim Committee (NUCC) Instructions**

*1500 Health Insurance Claim Form Reference Instruction Manual for Form  
Version 02/12*

*Version 1.1 06/13*

- **CMS/Medicare Instructions**

*Chapter 26 - Completing and Processing Form CMS-1500 Data Set  
(Rev. 2842, 12-27-13)*

Spring 2014 Update



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# CLAIM FORM INSTRUCTIONS

The following instructions for the 1500 are excerpts from NUCC and Medicare instructions, but they are generally universal. Consult with your specific insurance payer for their adaptations. However, these instructions apply to claims submitted on paper or electronically and must be used when filing claims with Medicare. Please note that payment rules can change frequently for any payer.

The instructions included in this section are compiled from the following documents along with commentary by InstaCode Institute:

- 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12 (version *1.1 06/13*), by the National Uniform Claim Committee (NUCC).
- Medicare instructions by CMS (Rev. 2842, 12-27-13) are added to the NUCC instructions in shaded areas.

## Conventions

### Item Number and Title are in bold text.

NUCC instructions are in regular text.

*NUCC description are in italic text.*

Medicare instructions are shaded.

Field specifications are omitted from this *InstaGuide*. (See the full instructions by the NUCC.)

Item examples are by NUCC.

Alerts, commentary and/or examples by InstaCode Institute are enclosed in a box like this

- ▶ ◀ Identifies new or revised official CMS or NUCC instructional text for this year.

## Official Instructions

### Overall Instructions

Each item includes the title, instructions, description, field specifications, and example. The examples provided in the instructions are demonstrating how to enter the data in the field. They are not providing instruction on how to bill for certain services.

#### Punctuation

The use of punctuation is noted in the instructions section of each Item Number.

#### Multiple Page Claims

When reporting line item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than four diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim.

**Please note:** Form images throughout this manual may not be to scale.

## Medicare Instructions

► The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Providers meeting an ASCA exception may send their claims to Medicare on a paper claim form. (For more information regarding ASCA exceptions, refer to Chapter 24.)

Providers sending professional and supplier claims to Medicare on paper must use Form CMS-1500 in a valid version. This form is maintained by the National Uniform Claim Committee (NUCC), an industry organization in which CMS participates. Any new version of the form must be approved by the White House Office of Management and Budget (OMB) before it can be used for submitting Medicare claims. When the NUCC changes the form, CMS coordinates its review, any changes, and approval with the OMB.

The NUCC has recently changed the Form CMS-1500, and the revised form received OMB approval on June 10, 2013. The revised form is version 02/12, OMB control number 0938-1197.

The revised form will replace the previous version of the form 08/05, OMB control number 0938-0999.

Throughout this chapter, the terms, “Form CMS-1500,” “Form 1500,” and “CMS-1500 claim form” may be used to describe this form depending upon the context and version. The term, “CMS-1500 claim form” refers to the form generically, independent of a given version.

Medicare will conduct a dual-use period during which providers can send Medicare claims on either the old or the revised forms. When the dual-use period is over, Medicare will accept paper claims on only the revised Form 1500, version 02/12.

For the implementation and dual-use dates, contractors shall consult the appropriate implementation change requests for the revised Form 1500. Providers and other interested parties may obtain the implementation dates on the CMS web site @ [www.cms.gov](http://www.cms.gov).

Reminder: Regardless of the paper claim form version in effect: **Providers cannot submit ICD-10 codes for claims with dates of service prior to October 1, 2014.** ◀

The following instructions ► are required for a Medicare claim. They apply to both the 08/05 and 02/12 versions of the form except where noted. A/B MACs (B) and DME MACs ◀ should provide information on completing the ► CMS-1500 claim form◀ to all physicians and suppliers in their area at least once a year.

► These instructions represent the minimum requirements for using this form to submit a Medicare claim. However, depending on a given Medicare policy, there may be other data that should also be included on the CMS-1500 claim form; if so, these additional requirements are addressed in the instructions you received for such policies (e.g., other chapters of this manual). ◀

Providers may use these instructions to complete this form. The ► CMS-1500 claim form ◀ has space for physicians and suppliers to provide information on other health insurance. This information can be used by ► A/B MACs (B) ◀ to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is another insurer to which Medicare can forward billing and payment data following adjudication if the provider is a physician or supplier that participates in Medicare. (See Pub 100-05, Medicare Secondary Payer Manual, Chapter 3, and Chapter 28 of this manual).

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Legend	Description
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 1998 = 98)
CCYY	4 position Year (e.g., 1998 = 1998)
(MM   DD   YY) or (MM   DD   CCYY)	A space must be reported between month, day, and year (e.g., 12   15   98 or 12   15   1998). This space is delineated by a dotted vertical line on the Form CMS-1500)
(MMDDYY) or (MMDDCCYY)	No space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

## Field Specific Instructions

### Carrier Block

*Description: The payer is the carrier, health plan, third-party administrator, or other payer ► that ◀ will handle the claim. This information directs the claim to the appropriate payer.*

The carrier block is located in the upper ►center and right margin of the form. In order to distinguish this version of the form from previous versions, the Quick Response (QR) code symbol and the date approved by the NUCC have been added to the top, left-hand margin.◀

### NUCC Instructions

Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format:


- 1st Line – Name
- 2nd Line – First line of address
- 3rd Line – Second line of address ►, if necessary ◀
- 4th Line – City, State (2 characters) and ZIP Code

For an address with three lines, enter it in the following format

- **Line**    **Descriptor**
- 4        Payer Name
- 5        Payer Address
- 6        Leave blank
- 7        Payer City State and ZIP

*Example:*

Four line address:



**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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ABC Insurance Company  
Suite 600  
567 Insurance Lane  
Big City IL 60605

CARRIER

- **Line**    **Descriptor**
- 4        Payer Name
- 5        Payer Address 1
- 6        Payer Address 2
- 7        Payer City State and ZIP

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Days or Units.....	38	Patient's Birth Date, Sex.....	14
Diagnosis or Nature of Illness or Injury.....	32	Patient's Condition Related To.....	20
Diagnosis Pointer.....	37	Patient's Name.....	14
EMG.....	37	Patient's or Authorized Person's Signature.....	23
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