

REVISED 1500 CLAIM FORM AND NPI INSTRUCTIONS

The National Uniform Claim Committee (NUCC) released a revised 1500 Claim Form, which is commonly referred to as the CMS-1500. The revised CMS-1500 (08/05) replaced the former CMS-1500 (12/90). Use of the revised form was required as of April 1, 2007. A sample form is attached for your review.

The 1500 Claim Form and NPI

Revisions to the 1500 Claim Form include several fields that accommodate the use of your National Provider Identifier (NPI).

Though the revised form accommodates NPI, you must continue to report **current** plan assigned provider identification numbers in the appropriate shaded areas of the form (17a, 24j, 32b, and 33b). Current provider identification numbers must be preceded by a two-character qualifier ID. This qualifier ID is the same as the qualifier ID used when billing electronically. If you do not currently bill electronically, please use the following ID: **N5**

Important Revisions to the 1500 Claim Form

The revised 1500 Claim Form expands the length of some existing fields, incorporates several new fields, and accommodates use of your NPI. Some important fields that have been revised or added are listed below [new fields are highlighted]:

Please Note: In addition to the revised fields, we will now require you to populate Field 19 with the ZZ qualifier ID and the Billing Provider's Primary Taxonomy Code (Example: ZZ207LP2900X).

Field 19	Field must be populated with the ZZ qualifier ID and the Billing Provider's Primary Taxonomy Code (Example: ZZ207LP2900X)
Field 21, parts 1-4	Diagnosis code fields have been updated to allow four characters of information following the pre-filled decimal point.
Field 24	The shaded area extending from fields 24A through 24G will accommodate supplemental information, such as the narrative description of unspecified codes.
Field 24C	"EMG" (previously "Type of Service"). EMG was previously Field 24I.
Field 24D	"Procedures, Services, or Supplies" has been extended by three characters; you may now record up to four modifiers on the same line.
Field 24E	Now titled "Diagnosis Pointer" (previously "Diagnosis Code"); size decreased by three characters.
Field 24H	"EPSDT Family Plan" decreased in size by one character.
Field 24I	"ID. Qual" (previously "EMG"). The shaded area of this field (part 1) allows you to identify the two-character qualifier ID of the Rendering Provider (Example: N5). The unshaded area (part 2) is pre-filled with "NPI." Field is required.
Field 24J	"Rendering Provider ID #" (previously "COB"). The shaded area of this field (part 1) allows you to submit the current provider identification number of the Rendering Provider that coincides with the two-character qualifier ID reported in the shaded area of 24I (part 1). The unshaded area (part 2) accommodates the Rendering Provider NPI. Both areas of this field are required.
Field 33a	Billing Provider NPI (previously "PIN#").
Field 33b	Billing Provider two-character qualifier ID and current provider identification number (Example: N51234567001) (previously "GRP#") Field is required.

For additional information about the 1500 Claim Form, please visit the NUCC's website at www.nucc.org. The NUCC offers a helpful Instruction Manual titled 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version, which features walkthroughs of each field of the 1500 Claim Form. You can currently access the guide in PDF form at the following location: http://www.nucc.org/images/stories/PDF/claim_form_manual_v1-3_7-06.pdf

We would also like to remind you of the requirements for electronic transactions. As a reminder, Passport Health Plan strongly recommends the continued use of plan identification numbers in addition to NPI.

837 P DATA FIELD REQUIREMENTS

----- 837 P ----- BILLING TAXONOMY LOOP -----					
LOOP ID	Loop Name	Segment Name	PRV01 Qualifier	PRV02 Qualifier	PRV03 Value
2000A	Billing/Pay-To Provider Specialty Information	PRV	BI	ZZ	= Taxonomy
			PT		
----- 837 P ----- BILLING PROVIDER LOOP -----					
LOOP ID	Loop Name	Segment Name	NM101 Qualifier	NM108 Qualifier	NM109 Value
2010AA	Billing Provider	NM1	85	24	= TAX ID
				34	= SSN
				XX	= NPI
LOOP ID	Loop Name	Segment Name	REF01 Qualifier		REF02 Value
2010AA	Billing Provider Secondary Identification	REF	SY		= SSN
			EI		= TAX ID
			1D		= MAID
----- 837 P ----- PAY TO PROVIDER LOOP -----					
LOOP ID	Loop Name	Segment Name	NM101 Qualifier	NM108 Qualifier	NM109 Value
2010AB	Pay-To-Provider	NM1	87	24	= TAX ID
				34	= SSN
				XX	= NPI
LOOP ID	Loop Name	Segment Name	REF01 Qualifier		REF02 Value
2010AB	Pay-To-Provider Secondary Identification	REF	SY		= SSN
			EI		= TAX ID
			1D		= MAID
----- 837 P ----- RENDERING PROVIDER LOOP -----					
LOOP ID	Loop Name	Segment Name	NM101 Qualifier	NM108 Qualifier	NM109 Value
2310B	Rendering Provider	NM1	82	24	= TAX ID
				34	= SSN
				XX	= NPI
LOOP ID	Loop Name	Segment Name	REF01 Qualifier	USED IN LOB	REF02 Value
2310B	Rendering Provider Secondary Identification	REF	N5		= Facets ID
----- 837 P ----- RENDERING PROVIDER TAXONOMY LOOP -----					
LOOP ID	Loop Name	Segment Name	PRV01 Qualifier	PRV02 Qualifier	PRV03 Value
2310B	Rendering Provider Specialty Information	PRV	PE	ZZ	= Taxonomy
----- 837 P ----- SERVICE FACILITY LOOP -----					
LOOP ID	Loop Name	Segment Name	NM101 Qualifier	NM108 Qualifier	NM109 Value
2310D	Service Facility Location	NM1	82	24	= TAX ID
				34	= SSN
				XX	= NPI
LOOP ID	Loop Name	Segment Name	REF01 Qualifier		REF02 Value
2310D	Service Facility Location Secondary Identification	REF	77		= Service Location
			FA		= Facility
			LI		= Independent Lab
			TL		= Testing Laboratory

Please let us know if you have any questions regarding these instructions. In addition, if you have any questions regarding the NPI, the application process, or reporting your NPIs to us, please contact your Provider Relations representative.

1500

HEALTH INSURANCE CLAIM FORM

REVISED

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA [] [] [] [] PICA [] [] [] []

1. MEDICARE [] MEDICAID [] TRICARE CHAMPUS [] CHAMPVA [] GROUP HEALTH PLAN [] FECA BLK LUNG [] OTHER [X] (ID) 1a. INSURED'S I.D. NUMBER (For Program in Item 1) ABC1234567800

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John B. 3. PATIENT'S BIRTH DATE MM DD YY 03 20 71 SEX M [X] F [] 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John B.

5. PATIENT'S ADDRESS (No., Street) 1234 Main Street 6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [] Child [] Other [] 7. INSURED'S ADDRESS (No., Street) 1234 Main Street

CITY Anytown STATE NJ 8. PATIENT STATUS Single [] Married [X] Other [] 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Mary

ZIP CODE 08999 TELEPHONE (Include Area Code) (856) 555-2222 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES [] NO [X] b. AUTO ACCIDENT? YES [] NO [X] c. OTHER ACCIDENT? YES [] NO [X]

11. INSURED'S POLICY GROUP OR FECA NUMBER 15974 a. INSURED'S DATE OF BIRTH MM DD YY 03 20 71 SEX M [X] F [] b. EMPLOYER'S NAME OR SCHOOL NAME Watch Repair, Inc. c. EMPLOYER'S NAME OR SCHOOL NAME self-employed d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [] If yes, return to and complete item 9 a-d.

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 _____ DATE _____ 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 _____ DATE _____

14. DATE OF CURRENT: MM DD YY 10 28 06 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Josephine Smith, M.D. 17a. G2 0123456789 17b. NPI 999999999 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 11 01 06 TO 11 04 06

19. RESERVED FOR LOCAL USE ZZ207LP2900X 20. OUTSIDE LAB? YES [] NO [] \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 401 2. 251 8 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 123456789

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #																		
11	02	06	11	02	06	21	6	99205		1	\$ 50 00	1									N5	1234567000							
11	03	06	11	03	06	21	6	20600	25	2	\$ 250 00	1																	

24. FEDERAL TAX ID NUMBER 22-1234567 25. 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.) Richard B. Smith, M.D. 26. SERVICE FACILITY LOCATION INFO ABC Hospital 123 Street Anytown, NJ 08999 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) 28. TOTAL CHARGE \$ 100 00 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$ 100 00

31. BILLING PROVIDER INFO & PH # (856) 555-5555 32. BILLING PROVIDER INFO & PH # ABC Medical Group 8 North American Street Anytown, NJ 08999 33. BILLING PROVIDER INFO & PH # (856) 555-5555

SIGNED _____ DATE 11/5/06 a. 0000001234 b. G21234567002 a. 2222222222 b. N51234567001

Member I.D. Number (No Suffix for CompSelect® Comprehensive Major Medical [CMM])

Referring Provider's two-character qualifier ID

Referring Provider's Current Provider ID

ZZ qualifier ID and Billing Provider's Primary Taxonomy Code

Referring Provider's NPI

Referral/Preauthorization Number

Two-character qualifier ID of the Rendering Provider

Provider's Federal Tax ID # (Billing Entity)

Service Facility NPI

Service Facility two-character qualifier and Current Provider ID number

Billing Provider NPI

Billing Provider two-character qualifier ID and current provider identification number

NUCC Instruction Manual available at: www.nucc.org OMB APPROVAL PENDING

Green items are required. Blue items are required when applicable to the patient's condition/situation. Black items are optional. Indicates new field and/or requirement. Indicates field required for processing.