CMS-1500 Form

Carrier information

Patient and insured information	
1. Select one:	1a. Insured's ID number (for program in item 1):
◯ MEDICARE (Medicare#) ◯ TRICARE (ID#/DoD#) ◯ GROUP HEALTH PLAN (ID#) ◯ MEDICAID (Medicaid#) ◯ CHAMPVA (member ID#) ◯ FECA BLK LUNG (ID#) ◯ OTHER (ID#)	
	2. Patient's name (Last name, first name, middle initial):
3. Patient's birth date:	Patient's sex:
	◯ M ◯ F
	4. Insured's name (Last name, first name, middle initial):

5. Patient's address:		**6. Patient's relationship to the insured:**	**7. Insured's address:**	
		◯ Self ◯ Spouse ◯ Child ◯ Other		
City:	State:	***8. Admin use only***	City:	State:
Telephone:	Zip:		Telephone:	Zip:

9. Other insured's name (Last name, first name, middle initial):	**10. Is patient's condition related to:**
	a. Employment? (current or previous): ◯ Yes ◯ No
9a. Other insured's policy or group number:	b. Auto accident? ◯ Yes ◯ No Place (state):
9b. Reserved for admin use / *9c. Reserved for admin use*	c. Other accident? ◯ Yes ◯ No
9d. Insurance plan name or program name:	10d. Claim codes:

11. Insured's policy group or FECA number:	11a. Insured's birth date:	Insured's sex:
		◯ M ◯ F
11b. Other claim ID:	11c. Insurance plan name or program name:	11d. Is there another health benefit plan? (if yes, complete items 9, 9a and 9d):
		◯ Yes ◯ No

12. Patient's or authorized person's signature I 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 or authorized person's signature I I authorize payment or medical benefits to the undersigned physician or supplier for services described below.

Signed:	Date:

Physician or supplier information

14. Date of current illness, injury, or pregnancy (LMP):	17. Name of referring provider or other source:	
15. Other date:	17a.	17b. NPI:
16. Dates patient unable to work in current occupation:	18. Hospitalization dates related to current services:	
From: To:	From:	To:

19. Additional claim information:

20. Outside lab? ◯ Yes ◯ No	$ Charges:

21. Diagnosis or nature of illness or injury (relate A-L to service line below (24E)):

A.	B.	C.	D.	E.	F.
G.	H.	I.	J.	K.	L.

22. Resubmission code:	Original ref. no.:	23. Prior authorization number:

24.	a. Dates of service	b. Place	c. EMG	d. Procedures, services or supplies	e. Diagnosis pointer	f. $ Charges	g. Days or units	h. EPSCT family plan	i. ID Qual.	j. Rendering provider ID#
1	From: To:			CPT/HCPCS: Modifier:					NPI	
2	From: To:			CPT/HCPCS: Modifier:					NPI	
3	From: To:			CPT/HCPCS: Modifier:					NPI	
4	From: To:			CPT/HCPCS: Modifier:					NPI	
5	From: To:			CPT/HCPCS: Modifier:					NPI	
6	From: To:			CPT/HCPCS: Modifier:					NPI	

25. Federal tax I.D. no.:	**26. Patient's account no.:**	**27. Accept assignment?**
◯ SSN ◯ EIN		◯ Yes ◯ No
28. Total charge: $	**29. Amount paid:** $	***30. Reserved for admin use***

31. Signature of physician or supplier including degrees or credentials I I certify that the statements on the reverse apply to this bill and are made a part thereof.

Signed:	Date:
32. Service facility location information:	**33. Billing provider info & Ph:**

32a. NPI:	32b.	33a.	33b.

Field specific instructions

Items 1-13: Patient and insured information

Note: If the patient can be identified by a unique Member Identification Number, the patient is considered to be the “insured”. The patient is reported as the insured in the insured data fields and not in the patient fields.

1. Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked. “Other” indicates health insurance including HMOs, commercial insurance, automobile accident, liability, or workers’ compensation. This information directs the claim to the correct program and may establish primary liability.
    - 1a. Enter the insured’s ID number as shown on insured’s ID card for the payer to which the claim is being submitted. If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field. For Tricare, Enter the DoD Benefits Number (DBN 11-digit number) from the back of the ID card. For worker’s compensation claims, enter the appropriate identifier of the employee. For other property and casualty claims, enter the appropriate identifier of the insured person or entity.
2. Enter the patient’s full last name, first name, and middle initial. For all names: if the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. If the patient’s name is the same as the insured’s name (i.e., the patient is the insured), then it is not necessary to report the patient’s name.
3. Enter the patient’s 8-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked. If sex is unknown, leave it blank.
4. Enter the insured’s full last name, first name, and middle initial.
5. Enter the patient’s address. For all addresses: the first line is for the street address; the second line, the city and state; the third line, the ZIP code. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen. If reporting a foreign address, contact payer for specific reporting instructions. If the patient’s address is the same as the insured’s address, then it is not necessary to report the patient’s address.
6. Enter an X in the correct box to indicate the patient’s relationship to insured when Item Number 4 is completed. Only one box can be marked. If the patient is a dependent, but has a unique Member Identification Number and the payer requires the identification number be reported on the claim, then report “Self”, since the patient is reported as the insured.
7. Enter the insured’s address.
8. This field was previously used to report “Patient Status.” “Patient Status” does not exist in 5010A1, so this field has been eliminated. This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.
9. If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured’s full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2.
    - 9a. Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number.
    - 9b. This field was previously used to report “Other Insured’s Date of Birth, Sex.” “Other Insured’s Date of Birth, Sex” does not exist in 5010A1, so this field has been eliminated.
    - 9c. This field was previously used to report “Employer’s Name or School Name. “Employer’s Name or School Name” does not exist in 5010A1, so this field has been eliminated.
    - 9d. Enter the other insured’s insurance plan or program name.
10. (a-c) When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if “YES” is marked in 10b for “auto accident.” Any item marked “YES” indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.
    - 10d. When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code.
11. Enter the insured’s policy or group number as it appears on the insured’s health care identification card. If Item Number 4 is completed, then this field should be completed.
    - 11a. Enter the 8-digit date of birth (MM | DD | YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.
    - 11b. Enter the “Other Claim ID.” Applicable claim identifiers are designated by the NUCC. When submitting to Property and Casualty payers, e.g. Automobile, Homeowner’s, or Workers’ Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:
      Y4 Agency Claim Number (Property Casualty Claim Number)
    - 11c. Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.
    - 11d. When appropriate, enter an X in the correct box. If marked “YES”, complete 9, 9a, and 9d. Only one box can be marked.

12. Enter “Signature on File,” “SOF,” or legal signature. When legal signature, enter date signed in 6-digit (MMIDDIYY) or 8-digit format (MMIDDIYYYY) format. If there is no signature on file, leave blank or enter “No Signature on File.”

13. Enter “Signature on File,” “SOF,” or legal signature. When legal signature, enter date signed in 6-digit (MMIDDIYY) or 8-digit format (MMIDDIYYYY) format. If there is no signature on file, leave blank or enter “No Signature on File.”

Items 14-33: Physician or supplier information

14. Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

    - Enter the applicable qualifier to identify which date is being reported.
      431 Onset of Current Symptoms or Illness
      484 Last Menstrual Period
    - Enter the qualifier to the right of the vertical, dotted line.

15. Enter another date related to the patient’s condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format. Enter the applicable qualifier to identify which date is being reported.

    - 454 Initial treatment
    - 304 Latest visit or consultation
    - 453 Acute manifestation of a chronic condition
    - 439 Accident
    - 455 Last X-ray
    - 471 Prescription
    - 090 Report start (assumed care date)
    - 091 Report end (relinquished care date)
    - 444 First visit or consultation

16. If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date must be shown for the “from–to” dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

17. Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

    1. Referring provider
    2. Ordering provider
    3. Supervising provider

    Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported.

    DN Referring provider
    DK Ordering provider
    DQ Supervising provider

    - Enter the qualifier to the left of the vertical, dotted line.
    - 17a. & 17b. (split field) The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
    - The NUCC defines the following qualifiers used in 5010A1:
      - 0B State license number
      - 1G Provider UPIN number
      - G2 Provider commercial number
      - LU location number (This qualifier is used for Supervising Provider only.)
    - Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

18. Enter the inpatient 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave the discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19. Please refer to the most current instructions from the public or private payer regarding the use of this field. Report the appropriate qualifier, when available, for the information being entered. Do not enter a space, hyphen, or other separator between the qualifier and the information. For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier “NTE”, followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words.

    - ADD Additional information
    - CER Certification narrative
    - DCP Goals, rehabilitation potential, or discharge plans
    - DGN Diagnosis description
    - TPO Third party organization totes

    For additional identifiers (REFs), the following are the qualifiers in 5010A1. Enter the qualifier “REF”, followed by the qualifier, then the identifier. Do not enter spaces between the qualifier and identifier.

    - 0B State license number
    - 1G Provider UPIN number
    - G2 Provider commercial number
    - LU Location number (This qualifier is used for supervising provider only.)
    - N5 Provider plan network identification number
    - SY Social security number (The social security number may not be used for Medicare.)
    - X5 State industrial accident provider number
    - ZZ Provider taxonomy (The qualifier in the 5010A1 for provider taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

    - Taxonomy codes or other identifiers reported in this field must not be reportable in other fields, i.e., Item Numbers 17, 24J, 32, or 33.

- For Supplemental Claim Information (PWK), the following are the qualifiers in the 5010A1. Enter the qualifier “PWK”, followed by the appropriate Report Type Code, the appropriate Transmission Type Code, then the Attachment Control Number. Do not enter spaces between the qualifiers and data.
- Report type codes:
  - 03 Report justifying treatment beyond utilization
  - 04 Drugs administered
  - 05 Treatment diagnosis
  - 06 Initial assessment
  - 07 Functional goals
  - 08 Plan of treatment
  - 09 Progress report
  - 10 Continued treatment
  - 11 Chemical analysis
  - 13 Certified test report
  - 15 Justification for admission
  - 21 Recovery plan
  - A3 Allergies/sensitivities document
  - A4 Autopsy report
  - AM Ambulance certification
  - AS Admission summary
  - B2 Prescription
  - B3 Physician order
  - B4 Referral form
  - BR Benchmark testing results
  - BS Baseline
  - BT Blanket test results
  - CB Chiropractic justification
  - CK Consent form(s)
  - CT Certification
  - D2 Drug profile document
  - DA Dental models
  - DB Durable medical equipment prescription
  - DG Diagnostic report
  - DJ Discharge monitoring report
  - DS Discharge summary
  - EB Explanation of benefits (coordination of benefits or medicare secondary payor)
  - HC Health certificate
  - HR Health clinic records
  - I5 Immunization record
  - IR State school immunization records
  - LA Laboratory results
  - M1 Medical record attachment
  - MT Models
  - NN Nursing notes
  - OB Operative note
  - OC Oxygen content averaging report
  - Report type codes:
    - OD Orders and treatments document
    - OE Objective physical examination (including vital signs) document
    - OX Oxygen therapy certification
    - OZ Support data for claim
    - P4 Pathology report
    - P5 Patient medical history document
    - PE Parenteral or enteral certification
    - PN Physical therapy notes
    - PO Prosthetics or orthotic certification
    - PQ Paramedical results
    - PY Physician’s report
    - PZ Physical therapy certification
    - RB Radiology films
    - RR Radiology reports
    - RT Report of tests and analysis report
    - RX Renewable oxygen content averaging report
    - SG Symptoms document
    - V5 Death notification
    - XP Photographs
  - Transmission type codes:
    - AA Avaliable on request at provider site
    - BM By mail

20. Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

    If “YES” is marked, enter the purchase price under “$ Charges” and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered. When entering the charge amount, enter the amount in the field to the left of the vertical line.

21. Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

    - 9 ICD-9-CM
    - 0 ICD-10-CM

    Relate lines A - L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.

22. List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field. When re-submitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

    - 7 Replacement of prior claim
    - 8 Void/cancel of prior claim

    This Item Number is not intended for use for original claim submissions.

23. Enter any of the following: prior authorization number, referral number, mammography certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. Do not enter hyphens or spaces within the number.

24. 24a. Enter date(s) of service, both the “From” and “To” dates. If there is only one date of service, enter that date under “From.” Leave “To” blank or re-enter “From” date. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24g. When required by payers to provide additional narrative description of an unspecified code, NDC, contract rate, or tooth numbers and areas of the oral cavity enter the applicable qualifier and number/code/ information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/ information.

    - 24b. In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.
    - 24c. Check with the payer to determine if this information (emergency indicator) is necessary. If required, enter Y for “YES” or leave blank if “NO”. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in 5010A1.
    - 24d. Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description.
    - 24e. In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM or ICD-9-CM diagnosis codes must be entered in Item Number 21. Do not enter them in 24E.
    - 24f. Enter the charge amount for each listed service. Enter the number right justified in the left-hand area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered.
    - 24g. Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.
    - 24h. For reporting of Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning services, refer to specific payer instructions. When EPSDT services are reported on this claim, identify the status of the referral by entering one of the following reason codes right justified:
        - AV Available – not used (patient refused referral.)
        - S2 Under treatment (patient is currently under treatment for referred diagnostic or corrective health problem.)
        - ST New service requested (referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)
        - NU Not used (used when no EPSDT patient referral was given.)

      When there is a requirement to report this is a Family Planning service, enter Y for “YES.” When there is no requirement to report this is a Family Planning service, leave the field blank.

    - 24i. Enter the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. The NUCC defines the following qualifiers used in 5010A:
        - 0B State license number
        - 1G Provider UPIN number
        - G2 Provider commercial number
        - LU Location number
        - ZZ Provider taxonomy (The qualifier in the 5010A1 for provider taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

      The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

      The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider’s information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

    - 24j. The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

25. Enter the “Federal Tax ID Number” (employer ID number or SSN) of the billing provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

26. Enter the patient’s account number assigned by the provider of service’s or supplier’s accounting system.

27. Enter an X in the correct box. Only one box can be marked. Report “Accept Assignment?” for all payers.

28. Enter the total charges for the services (i.e., total of all charges in 24F).

29. Enter the total amount the patient and/or other payers paid on the covered services only.

30. This field was previously used to report “Balance Due.” “Balance Due” does not exist in 5010A1, so this field has been eliminated. This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

31. “Signature of Physician or Supplier Including Degrees or Credential” does not exist in 5010A1. Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, “Signature on File,” or “SOF.” Enter either the 6-digit date (MMIDDIYY), 8-digit date (MMIDDIYYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

32. Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.

    - 32a. Enter the NPI number of the service facility location in 32a.Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

    - 32b. Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.
        - 0B State license number
        - G2 Provider commercial number
        - LU Location number

33. Enter the provider's or supplier's billing name, address, ZIP code, and phone number.

    - 33a. Enter the NPI number of the billing provider in 33a.

    - 33b. Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

    - The NUCC defines the following qualifiers used in 5010A1:
        - 0B State license number
        - G2 Provider commercial number
        - ZZ Provider taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)