INTRODUCTION

The CMS 1500 claim form is used to bill for non-facility services, including professional services, freestanding surgery centers, transportation, durable medical equipment, ambulatory surgery centers and independent laboratories.

SUCCESSFUL CMS 1500 CLAIM SUBMISSION TIPS

Format:
- Do not print, hand-write or stamp any extraneous data on the form.
- No hand-written corrections, no highlighting.
- Enter all information on the same horizontal plane within the designated field.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Use individual's name in provider signature, not a facility or practice name.

Accurate information is key:
- Put member’s name and ID numbers as it appears on member card.
- Include all applicable NPI numbers.
- Indicate the correct address including ZIP code where service was rendered, making sure address was reported to Network Representative and added to the Health Choice Arizona provider database.
- Ensure that the # of units/days and the dates of service range are not contradictory.
- Ensure that the quantity indicated in the procedure codes description are not contradictory.

Coding tips:
- Use current valid ICD-9 diagnosis codes and code them to the highest level of specificity (maximum number of digits) available.
  - Primary diagnosis
    - The primary diagnosis should describe the main condition or symptom of the patient.
    - For inpatient services, the primary diagnosis is the condition which was determined to be chiefly responsible for the inpatient stay, usually the discharge diagnosis.
Secondary/Additional Diagnosis

- This field should be used if there is a secondary and/or additional conditions or symptoms that affect the treatment.
- It is important that the secondary/additional diagnosis be indicated on inpatient stays when the length of stay or ancillary services have been affected.
- Diagnosis which relate to a previous illness and which have no bearing on the current encounter should not be reported.

- The number of anesthesia minutes should always be reported on each claim in Field 24G.
- Use current valid CPT and HPCS codes.
- Use current valid modifiers when necessary.
- DMS-4 diagnosis codes, and behavioral health services are not covered.

**DOCUMENTATION REQUIREMENTS**

Providers must include all required documentation with the claim submission. Failure to do so may result in denial of the claim. Health Choice Arizona reserves the right to request additional documentation of the claim.

**COMPLETING THE CMS 1500 CLAIM FORM**

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.”

1. **Program Block Required**
   - Check the second box labeled “Medicaid”.

   ![Program Block Checkboxes]

   1a. **Insured's ID Number**  
   - Required
   - Enter the recipient's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the Health Choice Arizona Verification Unit. (See Chapter 2, Member Eligibility and Member Services). Behavioral health providers must be sure to enter the client’s AHCCCS ID number, not the client’s BHS number.

   ![Insured's ID Number Box]
   
   A12345678
2. **Patient’s Name**
   Required
   Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

   2. PATIENT’S NAME (Last Name, First Name, Middle Initial)

   Holliday, John H.

3. **Patient’s Date of Birth and Sex**
   Required
   Enter the recipient’s date of birth. Check the appropriate box to indicate the patient’s gender.

   3. PATIENT’S BIRTH DATE SEX

   MM DD YY

   08 14 1951 M F

4. **Insured's Name**
   Not required

5. **Patient Address**
   Not required

6. **Patient Relationship to Insured**
   Not required

7. **Insured's Address**
   Not required

8. **Patient Status**
   Not required

9. **Other Insured’s Name**
   Required if applicable
   If the recipient has no coverage other than Health Choice Arizona, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

   9a. **Other Insured’s Policy or Group Number**
   Required if applicable
   Enter the group number of the other insurance.

   9b. **Other Insured's Date of Birth and Sex**
   Required if applicable
   If the other insured is not the Health Choice Arizona recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured’s birth. Check the appropriate box to indicate gender.

   9c. **Employer’s Name or School Name**
   Required if applicable
   Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

   9d. **Insurance Plan Name or Program Name**
   Required if applicable
Enter name of insurance company or program name that provides the insurance coverage.

10. **Is Patient’s Condition Related to:** Required if applicable
    Check "YES" or "NO" to indicate whether the patient’s condition is related to employment, an auto accident, or other accident. If the patient’s condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

    10. **IS PATIENT’S CONDITION RELATED TO:**
        a. **EMPLOYMENT? (CURRENT OR PREVIOUS)**
           YES   NO
        b. **AUTO ACCIDENT?**  
           YES   NO  **PLACE (State)**
        c. **OTHER ACCIDENT?**
           YES   NO

11. **Insured's Group Policy or FECA Number** Required if applicable
11a. **Insured's Date of Birth and Sex** Required if applicable
11b. **Employer's Name or School Name** Required if applicable
11c. **Insurance Plan Name or Program Name** Required if applicable
11d. **Is There Another Health Benefit Plan** Required if applicable
    Check the appropriate box to indicate coverage other than Health Choice Arizona. If “Yes” is checked, you must complete Fields 9a-d.

12. **Patient or Authorized Person's Signature** Not required
13. **Insured's or Authorized Person's Signature** Not required
14. **Date of Illness or Injury** Required if applicable
15. **Date of Same or Similar Illness** Not required
16. **Dates Patient Unable to Work in Current Occupation** Not required
17. **Name of Referring Physician** Required if applicable
17a. **ID Number of Referring Physician**
    The ordering provider is required for:
• Laboratory
• Radiology
• Medical and Surgical Supplies
• Respiratory DME
• Enteral and Parenteral Therapy
• Drugs (J-codes)
• Temporary K codes
• Orthotics
• Prosthetics
• Temporary Q codes
• Vision codes (V-codes)
• 97001-97546

Ordering providers can be a M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

17b. NPI # of Referring Provider Required

18. Hospitalization Dates Related to Current Services Not required

19. Reserved for Local Use Not required

20. Outside Lab and ($) Charges Not required

21. Diagnosis Codes Required
   Enter at least one ICD-9 diagnosis code describing the recipient’s condition. Behavioral health providers must not use DSM-4 diagnosis codes. Up to four diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

<table>
<thead>
<tr>
<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
</tr>
</tbody>
</table>

22. Medicaid Resubmission Code Required if applicable
   Enter the appropriate code (“A” or “V”) to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."
See Chapter 7, General Billing Rules, for information on resubmissions, adjustments, and voids.

23. Prior Authorization Number  
Not required

See Chapter 6, Authorizations and Referrals, for information on prior authorization.

24A. Date of Service and NDC (effective 7/1/12)  
Required/NDC if applicable

- In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

<table>
<thead>
<tr>
<th>24.</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE(S) OF SERVICE</td>
<td>Place of Service</td>
<td>PROCEDURE, SERVICES, OR SUPPLIES</td>
<td>MODIFIER</td>
<td></td>
</tr>
<tr>
<td>From MM DD YY</td>
<td>To MM DD YY</td>
<td>EMG</td>
<td>CPT/HCPCS</td>
<td></td>
</tr>
<tr>
<td>N400074115278 ML10</td>
<td>07 01 12</td>
<td>07 01 12</td>
<td>11</td>
<td>J1642</td>
</tr>
</tbody>
</table>

The beginning and ending service dates must be entered in the non-shaded area.

24B. Place of Service  
Required

Enter the two-digit code that describes the place of service.

<table>
<thead>
<tr>
<th>03</th>
<th>04</th>
<th>05</th>
<th>06</th>
<th>07</th>
<th>08</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>Homeless shelter</td>
<td>IHS Free-standing Facility</td>
<td>IHS Provider-based Facility</td>
<td>Tribal 638 Free-standing Facility</td>
<td>Tribal 638 Provider-based Facility</td>
<td>Office</td>
<td>Home</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>31</td>
<td>33</td>
<td>49</td>
<td>50</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>ER - Hospital</td>
<td>ASC</td>
<td>Birthing Center</td>
<td>Military Treatment Facility</td>
<td>Skilled Nursing Facility</td>
<td>Nursing Facility</td>
<td>Independent Clinic</td>
<td>FQHC</td>
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<tr>
<td>54</td>
<td>55</td>
<td>56</td>
<td>57</td>
<td>58</td>
<td>59</td>
<td>60</td>
<td>61</td>
<td>62</td>
</tr>
<tr>
<td>ICF/Mentally Retarded</td>
<td>Residential Substance Abuse Treatment Facility</td>
<td>Psych Residential Treatment Center</td>
<td>Non-residential Substance Abuse Treatment Facility</td>
<td>Mass Immunization Center</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Choice Arizona Provider Manual  
Chapter 8 Billing on the CMS 1500 Claim Form  
Reviewed September 2014  
Page 6 of 11
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<tbody>
<tr>
<td>14</td>
<td>Group Home</td>
<td>51</td>
<td>Inpatient Psych Facility</td>
<td>71</td>
<td>Public Health Clinic</td>
<td></td>
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</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
<td>52</td>
<td>Psych Facility - Partial</td>
<td>72</td>
<td>Rural Health Clinic</td>
<td></td>
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</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
<td>53</td>
<td>Community Mental Health Center</td>
<td>81</td>
<td>Independent Laboratory</td>
<td></td>
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</tbody>
</table>

### 24A. Place of Service

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<tbody>
<tr>
<td><strong>DATE(S) OF SERVICE</strong></td>
<td><strong>From</strong></td>
<td><strong>To</strong></td>
<td><strong>Place of Service</strong></td>
<td><strong>EMG</strong></td>
<td><strong>CPT/HCPCS</strong></td>
</tr>
<tr>
<td>MM</td>
<td>DD</td>
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<td>MM</td>
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#### 24C. EMG

**Required if applicable**

Mark this box with a “,” an “X,” or a “Y” if the service was an emergency service, regardless of where it was provided.

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<tbody>
<tr>
<td><strong>DATE(S) OF SERVICE</strong></td>
<td><strong>From</strong></td>
<td><strong>To</strong></td>
<td><strong>Place of Service</strong></td>
<td><strong>EMG</strong></td>
<td><strong>CPT/HCPCS</strong></td>
<td><strong>MODIFIER</strong></td>
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<td>MM</td>
<td>DD</td>
<td>YY</td>
<td>MM</td>
<td>DD</td>
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<td>11</td>
</tr>
</tbody>
</table>

#### 24D. Procedure and Procedure Modifier

**Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the same date of service, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment. If more than two modifiers are required to completely delineate the service provided, enter “99” as the first modifier, then list the modifiers being billed with the procedure code. Call Claims Customer Service to verify that a modifier is valid for a procedure code.

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<tbody>
<tr>
<td><strong>DATE(S) OF SERVICE</strong></td>
<td><strong>From</strong></td>
<td><strong>To</strong></td>
<td><strong>Place of Service</strong></td>
<td><strong>Type of Service</strong></td>
<td><strong>PROCEDURE, SERVICES, OR SUPPLIES</strong></td>
<td><strong>EMG</strong></td>
<td><strong>CPT/HCPCS</strong></td>
</tr>
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<td>MM</td>
<td>DD</td>
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<td>MM</td>
<td>DD</td>
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<td>71</td>
<td>010</td>
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</tbody>
</table>
24E. **Diagnosis Pointer Required**
Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the number of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), not the diagnosis code itself. If more than one number is entered, they should be in descending order of importance. **To avoid claim denials, ensure the DX code referenced in this field has a direct relationship to the CPT/HCPCS code billed.**

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>DIAGNOSIS POINTER</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>1</td>
<td>1, 2</td>
<td></td>
</tr>
</tbody>
</table>

24F. **Charges Required**
Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

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<tr>
<th>D</th>
<th>E</th>
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<th>H</th>
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</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>DIAGNOSIS CODE</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
<td>150</td>
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<td>79</td>
<td>00</td>
<td></td>
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</tbody>
</table>

24G. **Days or Units Required**
Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

<table>
<thead>
<tr>
<th>D</th>
<th>E</th>
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<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
<td>DIAGNOSIS CODE</td>
<td>$ CHARGES</td>
<td>DAYS OR UNITS</td>
<td>EPSDT Family Plan</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>MODIFIER</td>
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<td>2</td>
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<td></td>
<td>1</td>
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</tr>
</tbody>
</table>

24H. **EPSDT/Family Planning** Not required

24I. **ID Qualifier** Required if applicable
24J. Rendering Provider ID Number  Required

(SHADED AREA) – Use for COB INFORMATION  Required if applicable

Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient's Deductible has been met, enter zero (0) for the Deductible amount. For recipients and service covered by a third party payer, enter only the amount paid. Always attach a copy of the Medicare or other insurer’s EOB to the claim. If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied. See Chapter 14, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID #  Required

Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, the AHCCCS ID must be used. The provider number is required in 24J if the NPI listed in 33A is not the same as the provider rendering services.

<table>
<thead>
<tr>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Pointer</td>
<td>Charges</td>
<td>Days or Units</td>
<td>EPST Family Plan</td>
<td>ID Qual</td>
<td>Rendering Provider ID #</td>
</tr>
</tbody>
</table>

25. Federal Tax ID  Required

Enter the tax ID number and check the box labeled “EIN.” If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN.”

<table>
<thead>
<tr>
<th>25. FEDERAL TAX I.D. NUMBER</th>
<th>SSN</th>
<th>EIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>86-1234567</td>
<td>☐</td>
<td>x</td>
</tr>
</tbody>
</table>

26. Patient Account Number  Required if applicable

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. Health Choice Arizona will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider's own accounting or tracking system.

27. Accept Assignment  Not required
28. **Total Charge**

Enter the total for all charges for all lines on the claim.

<table>
<thead>
<tr>
<th>27. ACCEPT ASSIGNMENT?</th>
<th>28. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. BALANCE DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>$ 179</td>
<td>00</td>
<td>$</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. **Amount Paid**

Enter the total amount that the provider has been paid for this claim by all sources *other than Health Choice Arizona*. Do not enter any amounts expected to be paid by Health Choice Arizona.

30. **Balance Due**

Not required

31. **Signature and Date**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS**

(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

**SIGNED**

John Doe  
**DATE**  03/01/03

32. **Name and Address of Facility**

If the pay to address and the service address are the same, then box 32 is not required unless the rendering provider has multiple locations under the same TIN# then box 32 is required. **Box 32 CANNOT contain a post office box address; it must be a physical address.**

32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)**

- Arizona Hospital
- 123 Main Street
- Scottsdale, AZ 85252
- a. NPI  | b.
32A. NPI Required if applicable. If the service facility location is indicated, service facility NPI# must be entered.

32B. OTHER ID Not Required

33. Billing Provider Name, Address and Phone Number Required
Enter the provider name, address, and phone number. If a group is billing, enter the group biller’s name, address, and phone number.

33A. Billing Provider NPI Number Required

33B. Other ID – AHCCCS Provider Registration Number Required if applicable

** Note – NPI is required for all providers that are mandated to maintain an NPI number. For atypical provider types, box 33b must be completed.