



## Tips for Submitting CMS-1500 Paper Claims

Providers are encouraged to submit claims electronically. For information regarding electronic submission, contact Electronic Data Interchange Support Services (EDISS) at 1-800-967-7902. If electronic claims submission is not an option, paper claims must be submitted according to the following guidelines. This will ensure timely and accurate processing of claims through the Optical Character Recognition (OCR) system.

- Use red CMS-1500 claim forms, version (02-12) available 1/1/14. This form will be required beginning 4/1/14. Photocopies of claims are **not** acceptable through the OCR system.
- Print claims using 10-12 point ALL CAPS font with dark black ink. Dark blue or light black print, are often too light to be read correctly by the OCR equipment. If you need to manually correct information, write the corrections clearly with dark ink (no red ink) and cross out the unneeded or incorrect information.
- Do not use red pen, markers, or blue/green highlighters.
- Align the claim form so that all information is contained within the appropriate box. Poorly aligned data may be read incorrectly or missed entirely, resulting in incorrect processing of the claim.

The following tips will ensure prompt and accurate OCR translation of your CMS-1500 claims:

- Item 1a – Patient's benefit plan number. Submit the alpha prefix and patient's benefit plan number that is in effect at the time services are provided. Do not put a space between the alpha prefix and the patient's benefit plan number.
- Item 3 – Patient's birth date and sex. Enter the birth date in the MMDDCCYY format. Enter an "X" in the appropriate box designating the sex of the patient.
- Item 4 – Insured's name. Enter last name, first name, middle initial with spaces between. For example, "Jane A. Doe" should be shown as "DOE JANE A". Do not list as "SAME" when the patient is the same as the insured. This is also true for item 5 (Patient's Address) and item 7 (Insured's Address).
- Item 6 – Patient's relationship to the insured. Enter an "X" in the appropriate box to indicate the patient's relationship to the insured.
- Item 17b – National Provider Identifier (NPI) number of the referring, ordering or supervising provider.
- Item 19 – Reserved for local use. This field can be used for descriptions of unlisted CPT® codes and unspecified HCPCS. If more than twelve diagnosis codes are needed, additional diagnosis codes can be put in this field.
- Item 21 – Diagnosis or nature of illness or injury which relates to the service line 24E and should include no more than twelve diagnosis codes as indicated on the form. Enter up to twelve diagnosis codes in order of priority using the degree of specificity.

- Item 24A – Date (s) of service. Enter date (s) of service, “From” and ‘To” in MMDDYY format.
- Item 24B – Place of Service. A valid two-digit place of service must be included.

03 – School  
 04 – Homeless Shelter  
 11 – Office  
 12 – Home  
 13 – Assisted Living Facility  
 14 – Group Home  
 15 – Mobile Unit  
 20 – Urgent Care Facility  
 21 – Inpatient Hospital  
 22 – Outpatient Hospital  
 23 – Emergency Room – Hospital  
 24 – Ambulatory Surgical Center  
 25 – Birthing Center  
 26 – Military Treatment Facility  
 31 – Skilled Nursing Facility  
 32 – Nursing Facility  
 33 – Custodial Care Facility  
 34 – Hospice  
 41 – Ambulance – Land  
 42 – Ambulance – Air or Water  
 49 – Independent Clinic  
 50 – Federally Qualified Health Center  
 51 – Inpatient Psychiatric Facility  
 52 – Psychiatric Facility Partial Hospitalization  
 53 – Community Mental Health Center  
 54 – Intermediate Care Facility/Mentally Retarded  
 55 – Residential Substance Abuse Treatment Facility  
 56 – Psychiatric Residential Treatment Center  
 57 – Non-residential Substance Abuse Treatment Facility  
 60 – Mass Immunization Center  
 61 – Comprehensive Inpatient Rehabilitation Facility  
 62 – Comprehensive Outpatient Rehabilitation Facility  
 65 – End Stage Renal Disease Treatment Facility  
 71 – State or Local Public Health Clinic  
 72 – Rural Health Clinic  
 81 – Independent Laboratory  
 99 – Other Unlisted Facility

- Item 24D – Procedures, services or supplies. Enter the CPT® or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers.

- Item 24E – Diagnosis pointer. Include only the diagnosis pointers referencing the appropriate diagnosis code in item 21. Do not include diagnosis codes in item 24E. Only the alpha character should be included in 24E and not the specific code.
- Item 24F – The charge for each listed service. Negative or zero dollar amounts are not allowed. Enter 00 in the cents area if the amount is a whole number.
- Item 24G – 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.
- Item 24J – NPI of the rendering provider or facility. Laboratories, ambulatory surgery centers and other facilities where outside providers come to provide services must list the facility NPI as the rendering provider in 24J. The provider performing the service must bill for their services separately.
- Item 28 – Total charge for the services. Enter 00 in the cents area if the amount is a whole number.
- Item 32a – NPI of service facility location. The NPI of the location where services were provided must be included.
- Item 33a – Billing Provider NPI. The NPI of the billing provider must be included.
- If more than six detail lines of information are required, you must submit another CMS-1500 claim form with the additional data. Each claim form will be considered as a separate claim and must be totaled separately.