Sample CMS-1500 Claim

A sample claim of the most commonly used fields. Contact your insurance company for further information regarding data entry requirements.

PAYER NAME
PAYER ADDRESS
PAYER ADDRESS 2
CITY ST ZIP

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE [X] (Medicare #) | MEDICAID [ ] (Medicaid #) | TRICARE CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SAMPLE PATIENT

3. PATIENT'S BIRTH DATE (MM DD YY): 02 21 1967 — SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAMPLE PATIENT

5. PATIENT'S ADDRESS (No., Street): 123 MAIN STREET

CITY: CITY — STATE: ST

ZIP CODE: 99999 — TELEPHONE (Include Area Code): (555) 444 3333

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 123 MAIN STREET

CITY: CITY — STATE: ST

ZIP CODE: 99999 — TELEPHONE (Include Area Code): (555) 444 3333

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

b. AUTO ACCIDENT?: YES [ ] NO [X] — PLACE (State)

c. OTHER ACCIDENT?: YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM DD YY): 02 21 1967 — SEX: M [X] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 ______

14. DATE OF CURRENT (MM DD YY): 06292009 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY): FROM ______ TO ______

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY): FROM ______ TO ______

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?: YES [ ] NO [X] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 300 4
2. ______
3. ______
4. ______

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	24. 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. #
1	06222009	06222009	11		90806		1	70 00	1		NPI	
2	06292009	06292009	11		90806		1	70 00	1		NPI	
3	07012009	07012009	11		90806		1	70 00	1		NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 2223334444 — SSN [X] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X] NO [ ]

28. TOTAL CHARGE: $ 210 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 210 00

31. 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.)

SIGNATURE ON FILE

SIGNED — DATE 07012009

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI — b.

33. BILLING PROVIDER INFO & PH #: (555) 555 5555

SAMPLE DOCTOR
333 MAIN STREET
ANYTOWN MI 44444

a. 1234567890 — b.

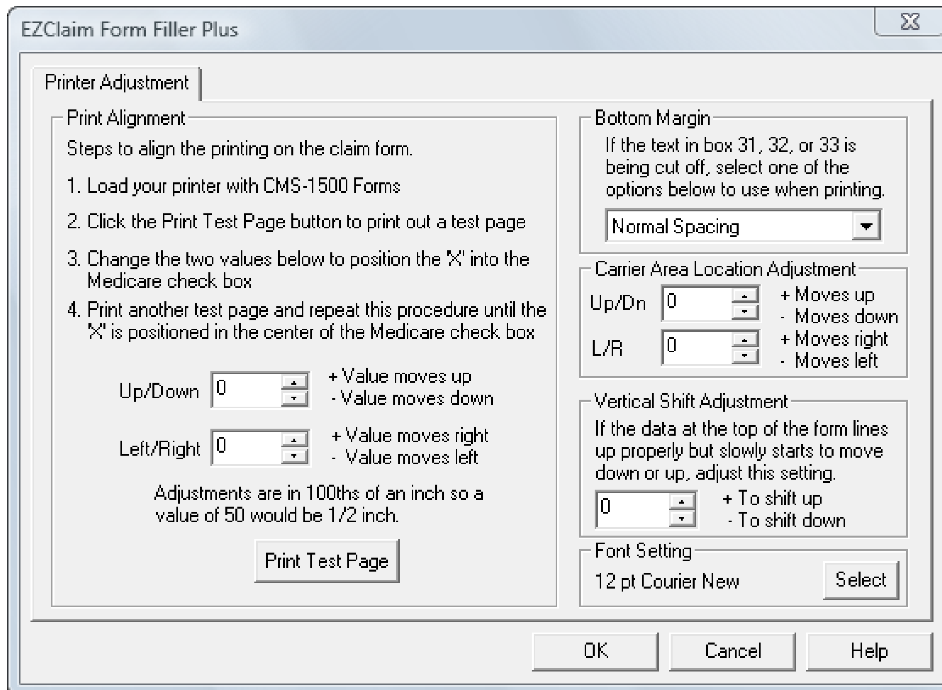
NUCC Instruction Manual available at: www.nucc.org

Printer Adjustment

Menu Location: File > Printer Adjustment

How do I adjust the Form Filler program to my printer?

IMPORTANT: You must use an original, pre-printed CMS-1500 form. Do not use a copied or faxed CMS-1500 form. Also, if you are using an ink-jet or laser printer, you must use the single sheet CMS-1500 forms. Do not use the multi-part continuous feed forms in a laser or inkjet printer.



Follow the steps below and your forms will print out correctly.

1. Click on ‘File’ on the menu bar and then ‘Printer Adjustment’.
2. Load your printer with CMS-1500 forms.
3. Click the ‘Print Test Page’ button.
4. Following Printer Adjustment instructions, change values until the X is positioned in the center of the Medicare check box at the top of the CMS-1500 form. (Suggestion: Continue using the same form until adjusted)
5. When adjustment is correct, click on OK.

Note: After setting printer values **you must click on OK** to set values.

Bottom Margin Adjustment

Menu Location: File > Printer Adjustment

When I print the 1500 form, boxes 31, 32 and 33 are being cut off. How do I adjust?

On some printers, the data at the bottom of the form will not print; adjust the font to ‘Smaller Font ‘or ‘Tight Spacing’.

1. Click on ‘File’ on the menu bar and then ‘Printer Adjustment’.
2. Go to ‘Bottom Margins’ and using the drop down arrow choose ‘Smaller Font’ or ‘Tight Spacing.’

Carrier Area Location Adjustment

Menu Location: File > Printer Adjustment

The insurance address is not centered in the envelope window. How do I adjust?

If you are using windowed envelopes it is recommended you use ‘claim form envelopes’. It may be necessary to adjust the carrier area to print out correctly for the envelope window.

1. Click on ‘File’ on the menu bar and then ‘Printer Adjustment’.
2. Go to ‘Carrier Area Location Adjustment’.

3. Adjust the ‘Up/Down’ and ‘Left/Right’ values as needed to line up the address with the envelope window.

Vertical Shift Adjustment

Menu Location: File > Printer Adjustment

The printing at the top is OK but the bottom is not, how do I adjust the printing?

Some printers do not feed the paper at the same speed as others. If the data on the CMS form starts to ‘shift’ out of position, you can use this setting to adjust it.

1. Click on ‘File’ on the menu bar and then ‘Printer Adjustment’.
2. Go to ‘Vertical Shift Adjustment’.
3. Adjust the ‘plus and minus’ values to shift the printing up or down.

Font Settings

Menu Location: File > Printer Adjustment

The font is too small (or large). How do I adjust the size of the font?

1. Click on ‘File’ on the menu bar and then ‘Printer Adjustment’.
2. Go to ‘Font Setting’.
3. Click on the ‘Select’ button.
4. Choose alternate font.

EZClaim Form Filler Quick Start

For National Uniform Claim Committee (NUCC) instructions on completing the 1500 form go to http://www.nucc.org/

Follow steps 1-5 to complete your first CMS 1500 form. Refer to the CMS 1500 form for 'Box' numbers.

Billing Library (Box 33) – Step 1

Menu Location: Tools > Billing Library

Required: Box 33 – Billing Name

1. Enter 'Billing Name', Address and NPI number.
2. Enter the Tax ID or SS# associated with the 'Billing Name' NPI.
3. 'Save' data.
4. Enter multiple 'Billing Info' data if provider information entered into Box 33 is different depending on the insurance company
5. This information will be selected using a 'dropdown' on the Physician/Diag Info tab when entering the claim data.

Deleting a Billing Library Entry

Note: Deleting a 'Billing Library' entry will delete the information from all claims using that Billing Provider Information. The following message will be displayed.

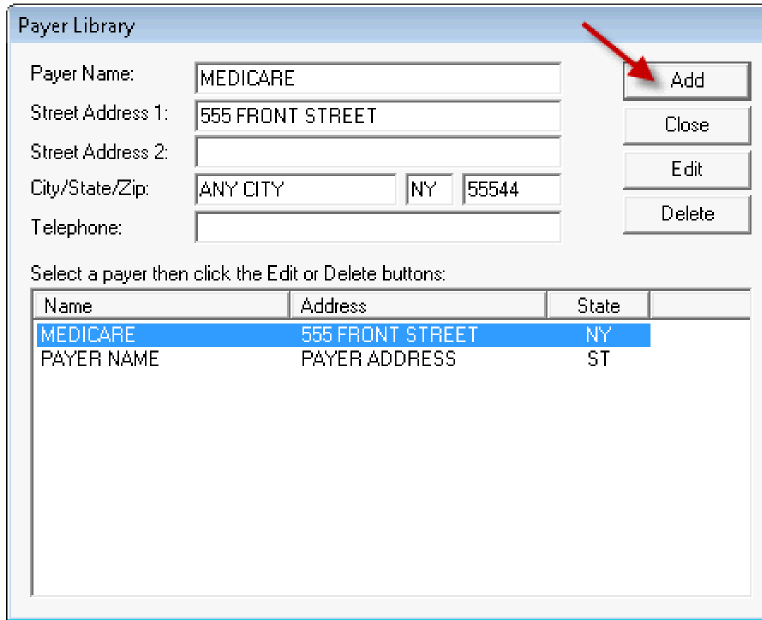
Payer Library - Step 2

Menu Location: Tools > Payer Library

Situational : Why would I use the Payer Library?

1. To keep a database of the Insurance Carrier used by the provider for submitting claims.
2. To enter Insurance Carrier address information in the Carrier Area. (Top right corner of CMS-1500 form.)

To open the Payer Library, click on the Tools menu and select 'Payer Library'.



Add Payer Information to Library

1. Enter name and address data
2. Click on the 'Add' button
3. 'Telephone' number will not print on the 1500 form.

Payer information is now listed in the box below.

Edit Payer Information in Library

To edit information in the Payer Library follow directions below.

1. Select by highlighting Payer to 'Edit' from the list in the Payer box.
2. Click the 'Edit' button or double click the payer.
3. Edit information
4. Click the 'Add' button

Payer information is now listed in the box below.

Delete Payer Information from Library

1. Select by highlighting the 'Payer' to be deleted
2. Click on the 'Delete' button.

Entering Claim Data

NO NEED TO USE A "**SAVE**" OR "**MEMORIZE**" FUNCTION WHEN ENTERING DATA. **ALL** DATA IS AUTOMATICALLY SAVED/MEMORIZED WHEN ENTERED INTO APPROPRIATE FIELDS.

Patient/Insured Info tab – Step 3

When Form Filler first starts, the ‘Patient/Insured Info’ screen is ready to input new patient data. This screen represents the top half of the CMS-1500 form, so enter data just as you would on a CMS-1500 form.

Most commonly used fields.

Box 1 - Select Insurance carrier by clicking in the check box.
Box 1a – Enter Insured ID Number.
Box 2 &5 - Enter Patient Information. (Once Patient Data is entered, you may use the Copy> button to copy data to right side of form.)
Box 3 – Enter Patient’s Birth Date.
Box 4 - Enter Insured information.
Box 6 - Check ‘Patient Relationship to Insured’.
Box 9 a-d – Other Insured Information if required.
Box 10 – Reserved for Local Use. Optional information determined by your insurance company.
Box 11 – Insured Policy Group or FECA Number if required.
Box 12 - Check ‘Patient Signature on File’. Enter Date or check date checkbox.
Box 13 –Check ‘Insured Signature on File’ if you are requesting payment of this claim to be sent to the Provider.

Enter any additional information if required by the insurance company.

Physician/Diagnostic Info tab - Step 4

This screen represents the bottom half of the CMS-1500 form along with additional data entry features.

Please Note: The following explains the areas on this screen that **do not** follow the CMS-1500 form exactly:

What are 'Default Values'?

The Default Values section on the Physician/Diagnostic screen is one of the reasons the Form Filler is so convenient and easy to use.

Often patients have the same codes for each date of service. Enter into this section **only those codes that are used** for every date of service for this patient. Most commonly used are 'Place of Service' and 'Rendering Provider' data.

When clicking on calendar dates from the 'New Charges Tab', these default entries will be automatically entered.

IMPORTANT NOTE: If using the Default Values section, data must be entered into Default section **BEFORE** entering data into the New Charges screen.

Note: Below are the most commonly used data entry fields, contact your insurance company for additional data requirements.

Box 14 - 'Date of Current' if required by your insurance company. Medicare usually requires this data.
Box 17 - If required by your insurance company, enter 'Referring Provider' name and NPI number.
Box 19 - Reserved for Local Use – Optional data entry determined by your insurance company.
Box 25 - Data will be automatically entered when the 'Billing Provider Info' is selected.
Box 26 - Enter 'Patient Account Number'. You may use a number of your choice or go to Tools>Options>Data Entry Options and check the box for "Automatically enter a Patient Acct. #".
Box 27 - Check the 'Accept Assignment' indicator, 'Yes' or 'No'.
Box 31 - Type Rendering Provider name in Box 31 or check 'Signature on File' and 'Print Date' checkbox.
Box 32 - Facility Information if required by your insurance company.

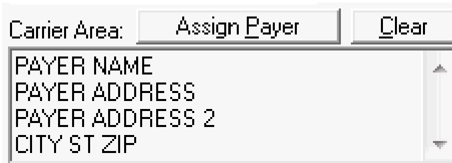
Box 33 - Billing Provider Info and NPI number. Use the dropdown to select 'Billing Info' previously entered under Tools>Billing Library.

- If required by your insurance company, enter Provider or Group number in the 'Qualifier and Other ID' field. See Qualifiers below.

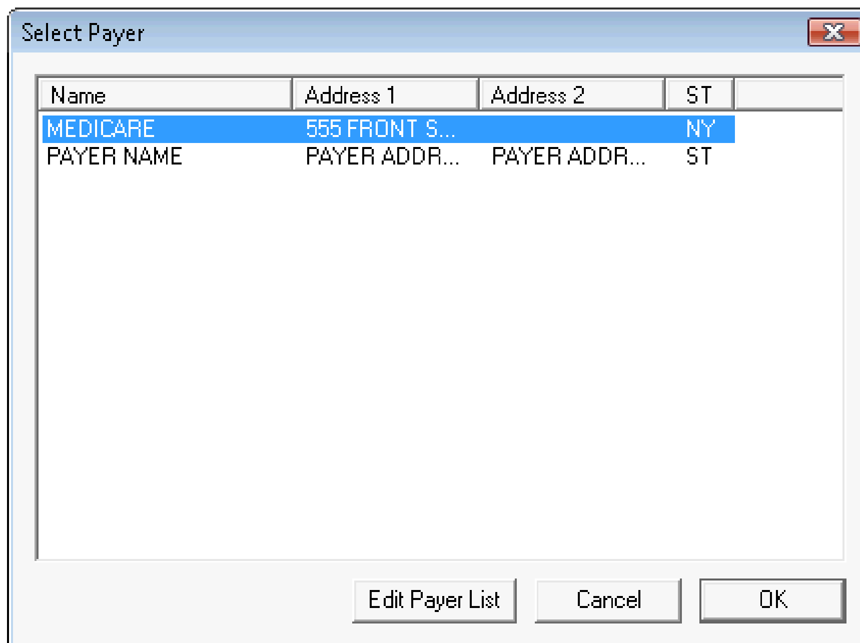
  0B - State License Number
  1B - Blue Shield Provider Number
  1C - Medicare Provider Number
  1D - Medicaid Provider Number
  1G - Provider UPIN Number
  1H - CHAMPUS Identification Number
  EI - Employer's Identification Number
  G2 - Provider Commercial Number
  LU - Location Number
  N5 - Provider Plan Network ID Number
  SY - Social Security Number
  X5 - State Industrial Accident Provider Number
  ZZ - Provider Taxonomy

Carrier Area for Payer Information

1. To enter the 'Insurance Name and Address' for this patient in the Carrier Area, go to the bottom left corner of the Physician/Diag screen. Click on 'Assign Payer' to open the Payer information previously set up in the Payer Library. See 'Step 2' for setting up the Payer Library.



2. Highlight Payer and click' OK'. Insurance company name is now listed in the Carrier Area and will print in the top right corner of your CMS 1500 form.



Charges tab – Step 5

Click on the **Charges** tab to enter dates of service.

Data entry tips

Box 21 - Enter diagnostic codes in the fields provided. (If you entered codes into the 'Claim Form Default' line on the **Physician/Diagnostic Info** screen, those codes will be automatically entered.)

- To enter Diagnostic codes, put your cursor in the box and enter code. Tab across the line to enter up to four DX codes.

Box 24a – Click on the calendar to select 'Date of Service'. If more than 6 dates of service are used, Form Filler will print multiple forms.
Box 24B - **Place of Service**: (Below are the most commonly used codes, contact your insurance company for additional codes)

11 - Office
12 - Home
21 - Inpatient Hospital
22 - Outpatient Hospital
24 - Ambulatory Surgical Center
31 - Skilled Nursing Facility
32 - Nursing Facility
33 - Custodial Care Facility
34 - Hospice
41 - Ambulance - Land
42 - Ambulance - Air or Water
53 - Community Mental Health Center
55 - Residential Substance Abuse Treatment Facility
71 – State or Local Public Health Clinic
72 – Rural Health Clinic
81 – Independent Laboratory
99 – Other Unlisted Facility

Box 24C – EMG – Leave blank unless required by your insurance company.
Box 24D – Enter 'Procedure Code'. Enter the Modifier if required by your insurance company.

Box 24E - Enter the diagnostic code line number (POINTER) on the charges line. Do not use the actual diagnosis code in this box, 24E, only pointers. If payer accepts more than one pointer per service line, use single digits separated by commas or spaces (i.e. 1, 2).

Box 24 J

- **NPI** - If required by the insurance company, enter the Rendering Provider NPI number in the 'Rend Prov ID' field.

>>	From	To	Place	EMG	CPT/HCPCS Procedure	Modifier	Diag Code Line #	Charge	Applied Amt	Units	EPSDT	Qual	Rend Prov ID
Del	4/17/2009	4/17/2009	11		90806		1	$70.00	$0.00	1			0987654321
Del	4/24/2009	4/24/2009	11		90806		1	$70.00	$0.00	1			
Del	5/1/2009	5/1/2009	11		90806		1	$70.00	$0.00	1			
Del													
Del													
Del													

Totals On Last Page Only — Total Charge and Amount Paid: $210.00 | $0.00 — Balance: $210.00

- **Provider (Legacy) Number** - If your insurance company requires a **Provider ID#** **and** **NPI#** in 24J, enter data in the following format.

1. Enter Qualifier in 'Qual' field. (See Qualifiers below)
2. Enter the Provider number in the 'Rendering Prov ID or NPI' field.
3. Enter an * and then the NPI number.

Charge	Applied Amt	Units	EPSDT	Qual	Rend Prov ID or NPI
$50.00	$0.00	1		1C	W4632*09876

4. Both the Provider and the NPI numbers will then print in 24J of the 1500 form.

I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1C	W4632
NPI	0987654321

Qualifiers

Enter Provider ID qualifier in 24I

0B - State License Number
1B - Blue Shield Provider Number
1C - Medicare Provider Number
1D - Medicaid Provider Number
1G - Provider UPIN Number
1H - CHAMPUS Identification Number
EI - Employer's Identification Number
G2 - Provider Commercial Number
LU - Location Number
N5 - Provider Plan Network ID Number
SY - Social Security Number
X5 - State Industrial Accident Provider Number

Line Item Descriptions

An insurance company may require a 'Line Item Description' to print in the shaded area above the line items in Box 24, see full EZClaim Form Filler manual under 'Charges Tab'.

Printing Claims – Step 6

Before printing your claims, see “Printer Adjustment” on page 2.

Single Claim: When you are finished entering date of service line items, confirm the CMS-1500 forms are in your printer and click the’ ***Print 1500’*** button to print the claim.

Multiple Claims: To print multiple claims go to ‘File’ on the Menu bar>Select Claims to Print. Select by highlighting claims and then ‘Print’.

Date Formats

When you print the claims, the dates are formatted according to the ‘Print Settings’ for each patient. Go to the Tools menu > Options > Print Options.

Printing a CMS-1500 form along with Data

Check the ‘Print Form & Data’ box at the lower right corner of the ‘Patient/Insured Info’ screen before printing your claim.