Claim Completion CMS 1500

The following claim completion instructions apply to all claims submitted to the MDCH by providers. Providers who submit claims to a Medicaid Health Plan (MHP) must contact that plan directly to determine if there are any different or additional requirements for claim completion.

1. Insurance: Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a. Insured's I.D. Number: Enter the patient's **ten-digit** Medicaid identification number.
2. Patient's Name: Enter the patient's last name, first name, and middle initial, if any.
3. Patient's Birth Date and Sex: Enter the patient's eight-digit birth date (MMDDCCYY) and sex.
4. Insured's Name: If there is private or group health insurance covering the beneficiary, list the name of the insured (policy holder) here. When the insured and the patient are the same, enter the word SAME. If there is no other insurance, leave blank.
5. Patient's Address: Enter the patient's mailing address and telephone number. On the first line, enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.
6. Patient Relationship to Insured: Check the appropriate box for patient's relationship to insured when item 4 is completed.
7. Insured's Address: Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.
8. Patient Status: Check the appropriate box for the patient's marital status and whether employed or a student.
9 Other Insured's Name: If the patient has more than one insurance in addition to Medicaid, enter the primary other insurance information in 11 through 11d and enter the name of the insured for the second commercial insurance here.
9a. Other Insured's Policy or Group Number: Enter the second insurance policy or group number.
9b. Other Insured's Date of Birth and Sex: Enter the insured's eight-digit date of birth (MMDDCCYY) and check the appropriate box for sex.
9c. Employer's Name or School Name: Enter the employer name or school name, if applicable.
9d. Insurance Plan Name or Program Name: Enter the plan or program name of the second insurance.
10a. Is Patient's Condition Related to Employment?: Check YES or NO as appropriate.
10b. Is Patient's Condition Related to Auto Accident?: Check YES or NO. If YES, the two-digit state code must be entered and the date of the accident must be reported in item 14.
10c. Is Patient's Condition Related to Other Accident?: Check YES or NO. If YES, the date of the accident must be reported in item 14.
10d. Reserved for Local Use: Leave blank. Not used by Medicaid.
11. Insured's Policy Group or Federal Employee Compensation Act (FECA) Number: This item MUST be completed if there is other insurance including Medicare. Enter the insured's policy or group number or HIC (Medicare Health Insurance Claim) number and proceed to items 11a. – 11c. Do NOT enter Medicaid information here.
11a. Insured's Date of Birth: Enter the insured's eight-digit date of birth (MMDDCCYY) and sex if different from item 3.
11b. **Employer's Name or School Name:** Enter the employer's name or school name if applicable.
11c. Insurance Plan Name or Program Name: Enter the complete insurance plan or program name.
11d. Is There Another Health Benefit Plan? If there is a second health benefit plan, mark the YES box and complete fields 9 through 9d. If no other plan, mark NO.
12. Patient's or Authorized Person's signature: Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to MDCH necessary to process the claim.
13. Insured's or Authorized Person's signature: Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to MDCH necessary to process the claim.
14. Date of Current Illness, Injury or Pregnancy: Enter the date of current illness, injury, or pregnancy as appropriate. If YES in item 10b or 10c, the date of accident is required. Report the date as eight digits (MMDDCCYY).
15. If Patient has had a same or similar illness, give first date: Leave blank. Not required by Medicaid.
16. Dates Patient Unable to Work in Current Occupation: Leave blank. Not required by Medicaid.

17. Name of Referring Physician or other Source: Enter the referring/ordering provider's first and last name, and professional designation (e.g., MD, DO). All covered services which are the result of a physician's order or referral must include the referring/ordering physician's name.
17a. I.D. Number of Referring Physician: Medicaid no longer utilizes this field.
17b. Enter the NPI number of the referring/ordering physician.
18. Hospitalization Dates Related to Current Services: When services are provided during an inpatient hospital stay, enter the date admitted and, if available, the date discharged. Report the dates as six or eight digits.
19. Reserved For Local Use: If services reported on the claim require documentation or special remarks, enter the information here.
20. Outside Lab/Charges: Leave blank. Not required by Medicaid.
21. Diagnosis or Nature of Illness or Injury: Enter the patient's diagnosis/condition that identifies the reason for the service. You must enter an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). Lab providers may use the laboratory examination code if a diagnosis is not available.
22. Medicaid Resubmission Code and Original Reference Number: Complete only if replacing or voiding/canceling a previously paid claim. If submitting a replacement claim, enter resubmission code 7 in the left side of item 22 and enter the 10- digit CRN of the paid claim you are replacing in the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 in the left side of item 22 and enter the 10- digit CRN of the paid claim you are voiding/canceling in the right side of item 22.
23. Prior Authorization Number: Enter the nine-digit Medicaid authorization number for services requiring authorization. Refer to the policy manual for specific requirements. Following are some of the services that require authorization:

- Elective inpatient services
- Out-of-state ambulance transports
- Select medical equipment and supplies
- Select prosthetic and orthotic services
- Select vision services
- Transplant services
- Other services as described in the provider policy manual or the Medicaid Databases.

Clinical Laboratory Services:
Enter the CLIA number here when billing for clinical lab services. The CLIA number is a 10-digit number with "D" in the third position.
24A. Date(s) of Service: Enter the six or eight-digit for each procedure, service or supply. List each date of service on a separate line. Both the "From" and "To" date must be completed. Refer to the Special Billing Section for instructions on reporting the date of service in special circumstances.
24B. Place of Service: Enter the appropriate two-digit place of service code from the list of CMS approved definitions for place of service below:
03 School: A facility whose primary purpose is education.
04 Homeless Shelter: A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05 Indian Health Service Free-standing Facility: A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06 Indian Health Service Provider-based Facility: A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07 Tribal 638 Free-standing Facility: A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08 Tribal 638 Provider-based Facility: A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatient or outpatient.

11 Office: Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12 Home: Location, other than a hospital or other facility, where the patient receives care in a private residence.
13 Assisted Living Facility: Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24-hours-a-day, 7-days-a-week, with the capacity to deliver or arrange for services, including some health care and other services.
14 Group Home: Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and support services and that promotes rehabilitation and reintegration of residents into the community.
15 Mobile Unit: A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
20 Urgent Care Facility: Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21 Inpatient Hospital: A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
22 Outpatient Hospital: A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23 Emergency Room – Hospital: A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24 Ambulatory Surgical Center: A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25 Birthing Center: A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26 Military Treatment Facility: A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31 Skilled Nursing Facility: A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32 Nursing Facility: A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
33 Custodial Care Facility: A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34 Hospice: A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41 Ambulance – Land: A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42 Ambulance – Air or Water: An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
49 Independent Clinic: A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50 Federally Qualified Health Center: A facility located in a medically underserved area that provides beneficiaries preventive primary medical care under the general direction of a physician.
51 Inpatient Psychiatric Facility: A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52 Psychiatric Facility - Partial Hospitalization: A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require fulltime

hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center: A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54 Intermediate Care Facility/Mentally Retarded: A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility: A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center: A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57 Non-residential Substance Abuse Treatment Facility: A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

60 Mass Immunization Center: A location where providers administer pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall, but may include a physician office setting.

61 Comprehensive Inpatient Rehabilitation Facility: A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility: A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65 End-stage Renal Disease Treatment Facility: A facility other than a hospital which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

71 Public Health Clinic: A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic: A certified facility which is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

81 Independent Laboratory: A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

99 Other Place of Service: Other place of service not identified above. (Provide description in item 32.)

Note: MDCH does not recognize place of service 05, 06, 08, 26, 54, or 60 as locations for provision of covered services. Additionally, some locations may be covered only for select providers. Refer to your policy manual for more information.

24C. EMG – Emergency: Enter the appropriate emergency code:

Y = emergency

N = not an emergency

24D. Procedures, Services, or Supplies (CPT/HCPCS Codes plus modifiers): Enter the code for the procedure, service, or supply rendered. Some procedure codes require the use of 2-character modifiers to accurately identify the service provided and to avoid delay or denial of payment. Up to two modifiers can be reported on one service line. If more than two must be reported, use the most pertinent modifier in the first position, modifier 99 in the second position, and identify the additional modifier(s) in item 19.

Refer to the Modifier section of the Professional Billing & Reimbursement chapter for a list of the modifiers that must be reported to Medicaid. Additional information on use is found in the policy manual. Other modifiers may be reported for informational purposes only.
If a code for the exact procedure cannot be found, use the appropriate unlisted services or Not Otherwise Classified (NOC) code listed within the service classification. Enter a complete description of the service in item 19 or attach the appropriate documentation. Do not use initials or abbreviations, unless they are universally known.
24E. Diagnosis Code (Pointer): Enter the primary diagnosis code pointer or reference number (i.e., 1, 2, 3, or 4) from item 21 which reflects the reason the procedure was performed. The primary diagnosis must always be reported as the first number. An "E" code cannot be reported as a primary diagnosis. Up to 4 pointers (reference numbers) may be reported per line. Do not report the actual diagnosis code in this item.
24F. Charges: Enter your usual and customary charge to the general public. Do not use decimals, commas, or dollar signs. Fifty dollars is recorded as 5000.
When billing Medicaid for services covered by Medicare, report the Medicare allowable amount.
When billing Medicaid for services covered by other third party carriers who have participating provider agreements in effect, report the carrier's allowable amount.
For beneficiaries enrolled in a commercial HMO or a Medicare risk HMO, report the fixed co-pay amount for the service as the charge.
24G. Days or Units: Enter the number of days or units. If only one service is performed, the number "1" must be entered.
Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., mileage, allergy testing, injectable drug dosages, medical supply items). When multiple services are provided, enter the actual number provided.
For anesthesia claims, enter the total anesthesia time in minutes. Convert hours into minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units.
Refer to the policy manual for additional information on billing quantity in special circumstances.
24H. EPSDT/Family Plan: Leave blank. Not required by Medicaid.
24I. ID Qualifier: if reporting Medicaid 9 digit legacy ID# use '1D' (optional).
24J. For LHD report the Medical Director's NPI#.
*** If the LHD has changed their Medical Director, they must notify the Hospital and Health Plan Reimbursement Section.**

24A-D NDC Supplemental Information
(Shaded Area) To assist Medicaid in collecting rebates for physician administered drugs, report the following National Drug Code (NDC) supplemental information in the shaded line of Field 24:
ÿÿ N4 (2-digit qualifier)
ÿÿ National Drug Codes (NDC) - 11-digit code with 5-4-2 format)
ÿÿ Description of Drug
ÿÿ Unit of Measurement Value (2-digit qualifier)
ÿÿ NDC Quantity

25. Federal Tax I.D. Number (check box/SSN or EIN): Enter your provider of service or supplier Federal Tax I.D. number (Employer Identification Number) or your Social Security Number. Check the box of the number reported. **Note:** The EIN or SSN reported here must correspond with the billing provider ID# in item 33.
26. Patient's Account Number: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is to assist you in patient identification. As a service, account numbers reported here will be reported back to you on the remittance advice.
27. Accept Assignment: Leave blank. Not required for Medicaid.
28. Total Charge: Enter total of charges from item 24F, lines 1-6.
29. Amount Paid: Enter the total amount of all payments/spend-down liability reported in item
30. Balance Due: Enter the balance due (from Medicaid) by subtracting Amount Paid (item 29) from Total Charge (item 28).
31. Signature of Physician or Supplier including degrees or credentials: A signature is required. See Chapter I for the provider certification requirements and acceptable signatures for the claim form.
32. Name and Address of Facility Where Services Were Rendered: Enter the name and complete address of the facility where the services were rendered.

32a. Enter the NPI number of the service facility location.

33. Physician's, Supplier's Billing Name, Address, Zip code and Phone: Enter the provider of service/supplier's billing name, address, zip code and telephone number.
33a. Enter the provider's business NPI number.
33b. Not required

Mandatory: Item is **required** for all claims. If the item is left blank, the claim cannot be processed.
Conditional: Item is required if applicable. Your claim may not be processed if blank.

Item Status Information
1a Mandatory Enter the patient's 8-digit Medicaid ID number.
2 Mandatory Enter the patient's last name, first name, middle initial, if any.
3 Mandatory Enter the patient's 8-digit birth date (MMDDCCYY) and sex.
4 Conditional, Mandatory if the patient has insurance primary to Medicaid.
6 Conditional, If item 4 is complete, check the appropriate box.
7 Conditional Complete if items 4 and 11 are completed.
9 Conditional, Mandatory if item 11d. is YES.
9a Conditional Enter second insurance policy or group number for policyholder in item 9.
9b Conditional Enter date of birth (MMDDCCYY) and sex for policyholder in item 9.
9c Conditional Enter employer or school name for policyholder in item 9.
9d Conditional Enter insurance plan name or program name for policyholder in item 9.
10a Mandatory Check YES or NO if condition is employment related.
10b Mandatory Check YES or NO if condition is related to an auto accident. If YES, indicate the state postal code.
10c Mandatory Check YES or NO if condition is related to accident other than auto.
11 Conditional Mandatory if patient has insurance primary to Medicaid. Enter primary insurance policy group number.
11a Conditional Enter the date of birth (MMDDCCYY) and sex for policyholder in item 4.
11b Conditional Enter the employer's name or school for policyholder in item 4.
11c Conditional Enter the insurance plan or program name for policyholder in item 4.
11d Conditional Check YES if appropriate and complete items 9-9d.
14 Conditional, If item 10b or 10c is YES, date of accident must be reported.
17 Conditional Enter the referring/ordering physician's name as required.
17a Conditional Enter the 9-digit Medicaid provider ID# of the provider in item 17.
17b Mandatory Enter NPI#
18 Conditional Report the admit & discharge dates for services during an inpatient hospital stay.
19 Conditional Enter documentation or remarks as required.
21 Mandatory Enter the ICD-9-CM diagnosis code(s) that identify the reason for the service.
22 Conditional Resubmit code 7 & the last paid 10-digit CRN is mandatory to replace a previously paid claim. Resubmit code 8 & the last paid 10-digit CRN is mandatory to void/cancel a previously paid claim.
23 Conditional Enter nine-digit Medicaid authorization number or ten-digit CLIA number as appropriate.
24A Mandatory Enter the eight-digit (MMDDCCYY) 'from' and 'to' date for each service.
24B Mandatory Enter the appropriate two-digit place of service code.
24C Mandatory Enter the EMG code Y it an emergency or a N if not an emergency
24D Mandatory Enter code and modifier (if appropriate) for the procedure, service or supply rendered.
24E Mandatory Enter the reference number(s) from item 21 that relates to the procedure/service. Report the primary diagnosis reference number first.
24F Mandatory Enter your charge without decimals, commas, or dollar signs.
24G Mandatory Enter the number of units.
24H EPSDT Medicaid does not use.
24I Conditional ID Qualifier use ID if reflecting the legacy provider ID#
24J Mandatory Enter Medical Director's NPI#

BILLING AND REIMBURSEMENT CLAIM COMPLETION

Item Status Information

Item	Status	Information
25	Mandatory	Enter the provider’s Federal Tax I.D. or Social Security Number.
26	Mandatory	Enter the patient account number assigned by the provider or supplier.
28	Mandatory	Enter sum of charges in item 24F.
29	Conditional,	Mandatory if entries in item 24K. Enter sum of entries in item 24K.
30	Mandatory	Enter amount in item 28 less amount in item 29.
31	Mandatory	Signature of provider or supplier and date.
32	Mandatory	Enter name & address of facility where services were rendered.
32a	Mandatory	Enter NPI# of facility where services rendered
33	Mandatory	Enter the provider’s name and complete address for the location of service billed.
33a	Mandatory	Enter provider’s business NPI#