Revision Dates: 11/23/2018; 10/1/2018; 7/10/2018; 7/3/2018; 4/20/2018; 3/23/2018; 10/15/2015; 9/14/2015; 5/31/2012

General Information on the CMS 1500 Claim Form & Claim Submissions

Please read the below section in full, prior to proceeding to the section called *Completing the CMS 1500 Claim Form*.

The following instructions explain how to complete the CMS 1500 Claim Form and whether a field is "Required," "Required if applicable," or "Not required."

These instructions are only applicable to filling out a **paper CMS 1500 claim form.**

- Note: The preferred method of claim submission remains the HIPAA-compliant 837 transaction process.

  If a provider is not set up to perform the 837 transaction process, then the preferred method of claim submission is via the AHCCCS Online Provider Portal. Only one claim at a time can be submitted via the AHCCCS Online Provider Portal, as it is not set up to accept batches.

  The preferred method of submission for **replacement/voided** claims is via the AHCCCS Online Provider Portal.

  For information on how to submit claims using the HIPAA-compliant 837 transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate implementation guides. Companion documents for 837 transactions are available on the AHCCCS website at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgical centers and independent laboratories also must bill for services using the CMS 1500 claim form. FQHC services may also be billed on a CMS 1500 claim form.

CPT and HCPCS procedure codes must be used to identify all services.

ICD-10 codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

All claims must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 31.

The preferred font for claim submission is Lucinda Console and the preferred font size is 10.

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

For the purposes of this chapter the term "member" refers to an AHCCCS eligible member.

Completing the CMS-1500 Claim Form

The revised CMS-1500 health insurance claim form version 02/12 replaced version 08/05. On the new version 02/12 the 1500 symbol at the top left corner is replaced with a scanable Quick Response (QR) code symbol and the date approved by the NUCC.

Effective 4/1/2014, the revised CMS-1500 version 02/12 will be required**.** Data receipt for 4/1/2014 and forward received with the old CMS 1500 08/05 form will be returned to the provider, regardless of the date of service being billed for on the claim.

1. Program Block — Required

Mark the second box labeled "Medicaid."

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(Medicare#)*	☒ *(Medicaid#)*	☐ *(ID# / DoD#)*	☐ *(member ID #)*	☐ *(ID#)*	☐ *(ID#)*	☐ *(ID#)*

1a. Insured's ID Number — Required

Enter the member's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. For additional information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual.

Behavioral Health providers must be sure to enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER	(FOR PROGRAM IN ITEM 1)
A99999999	

2. Patient's Name **Required**

Enter member'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)
Doe, John

3. Patient's Date of Birth and Sex **Date of Birth is Required**
Sex is Required if Applicable

Enter the member's date of birth. Mark the appropriate box to indicate the patient's gender, if applicable.

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY		
01	**1**	**19XX**	M ☒	F ☐

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

Enter the insured person's last name, first name, and middle initial.

5. Patient Address **Not Required**

Enter the member's street number, street name, city, state, zip code, and telephone (including area code) in the indicated fields.

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

Mark the appropriate box to indicate the patient's relationship to the insured person (self, spouse, child, or other).

7. Insured's Address (Street & Street Number) **Not Required**

8. Reserved for NUCC Use **Not Required**

9. Other Insured's Name **Required if applicable**

If the member has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the member, enter "Same."

9a. Other Insured's Policy or Group Number **Required if applicable**

Enter the policy or group number of the other insured.

9b. Reserved for NUCC Use **Not Required**

9c. Reserved for NUCC Use **Not Required**

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**

Mark "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) AZ
c. OTHER ACCIDENT?	☐ YES	☒ NO

10d. Claim Codes (Designated by NUCC) **Not Required**

11. Insured's Policy Group or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

11b. Other Claim ID (Designated by NUCC) **Not Required**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**

Mark the appropriate box to indicate coverage other than AHCCCS. If "Yes" is marked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Required**

If the signature is on file, then stating that the signature is on file is acceptable.

The signature may be handwritten, but it must be done in black pen.

13. Insured's or Authorized Person's Signature **Required if applicable**

If the member is under 18 years of age, then a signature is required from the insured member/authorized person. If the signature is on file, then stating that the signature is on file is acceptable.

The signature may be handwritten, but it must be done in black pen.

14. Date of Illness, Injury, or Pregnancy (LMP) **Required if applicable**

15. Other Date **Not Required**

16. Dates Patient Unable to Work in Current Occupation **Not Required**

17. Name of Referring Provider or Other Source **Required if applicable**

If applicable, enter the Qualifier:

DN Referring Provider
DK Ordering Provider*****
DQ Supervising Provider

Next, enter the name of the provider or other source.

***** The ordering provider is *required* for:

Laboratory	Drugs (J-codes)
Radiology	Temporary K and Q codes
Medical and surgical supplies	Orthotics

Respiratory DME	Prosthetics
Enteral and Parenteral Therapy	Vision codes (V-codes)
Durable Medical Equipment	97001 – 97546

Ordering provider can be any of the following: M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ID Number of Provider **Required if applicable**

17b. NPI # of Provider **Required**

18. Hospitalization Dates Related to Current Services **Not required**

19. Additional Claim Information (Designated by NUCC) **Required if applicable**

Any additional information required for the processing of a claim (that is not found in another field) shall be entered under the Additional Claim Information field.

The standard format is as follows:
FQHC Indicator\Any other additional information

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

The CRN and the original reference number are the same.

In the remarks section, for FQHC professional claims, the claims processing system is only able to accept *one* provider name at a time. If two providers are providing services to a member at the FQHC, please see Chapter 10, Addendum FQHC/RHC, for additional information. The standard FQHC format is as follows:

- If the provider has a NPI: XXNPIProviderName; *or*
- If the provider does not have a NPI: 999999999ProviderName
  Example: XX1234567890Smith, Hillary

For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Examples:

- An FQHC provider is submitting an original claim:
  XX1234567890Smith, Andrew

  If this provider had additional information to add after the FQHC indicator, then a backslash would be needed after the provider name.
  XX1234567890Smith, Andrew\Additional information here

- An FQHC provider is billing for a replacement claim of a previous submission:
  XX1234567890Smith, Hillary

  If this provider had additional information to add after the FQHC indicator, then a backslash would be needed after the provider name.
  XX1234567890Smith, Stacy\Additional information here

For questions on this field please outreach the provider training e-mail inbox at ProviderTrainingFFS@azahcccs.gov.

20. Outside Lab and $ Charges **Not required**

21. Diagnosis Codes **Required**

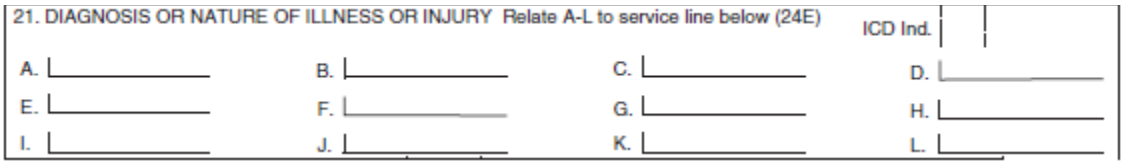
Enter at least one ICD diagnosis code describing the member's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

ICD Ind. Field: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM
9 = ICD-9-CM (no longer accepted)

- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

Enter the ICD indicator between the vertical, dotted lines in the upper-right hand area of the field.



Field A is the Principal Diagnosis.

Relate diagnosis lines A – L to the lines of service in 24E by the letter.

22. Medicaid Resubmission Code & Original Ref. No. Required if applicable

Enter the appropriate code ("7" or "8") to indicate whether this claim is a replacement (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 replaced or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7 or 8	130010004321

23. Prior Authorization Number Not required

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process. See Chapter 8, Authorizations, of the Fee-For-Service Provider Billing Manual for information on prior authorization.

24. A NOTE regarding field 24 (A-J) and multi-page claim submissions:

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page**

cannot be submitted unless all lines on page 1 are utilized and completely filled in first.

24. Service line (shaded area) **Required if applicable**

Enter the NDC Qualifier N4 in the first 2 positions. Next, enter the 11-digit NDC *immediately* after the NDC Qualifier N4, with no dashes or spaces separating them. Follow this with a space, followed by the NDC Unit of Measure Qualifier, followed by the NDC quantity *administered* to the patient.

Example: N400074115278 ML10

NDC Unit of Measure:

- F2 International Unit
- GR gram
- ML milliliter
- UN unit (each)

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
N400074115278 ML10									
07	01	13	07	01	13	11		J1642	

Note: Enter in only 1 NDC per service line/HCPCS code.

24A. Date(s) of Service **Required**

Enter the beginning and ending service dates.

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER

N400074115278 ML10											
07	01	13	07	01	13	11		J1642			

24B. Place of Service **Required**

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

Refer to the Current Procedural Terminology (CPT) manual for a complete listing of places of service.

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
N400074115278 ML10									
07	01	13	07	01	13	11		J1642	

24C. EMG – Emergency Indicator **Required if applicable**

Mark this box with a "Y" if the service was an emergency service, regardless of where it was provided.

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			Of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
							Y		

24D. Procedures, Services, or Supplies **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 to indicate the number of times the

service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT coding manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment.

24. A						B	C	D			
DATE(S) OF SERVICE From MM DD YY			To MM DD YY			Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		
								71010	**26**		

24. F $ Charges	G Days Or Units	H EPSDT Family Plan	I ID Qual.
	3		

24E. Diagnosis Pointer **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), not the diagnosis code itself. If more than one letter is entered, they should be in descending order of importance. Do not separate letters with commas.

D PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan
		A			
		AB			

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.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150 00		
			79 00		

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 coding manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
				3	
				1	

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

24I. ID Qualifier **Required**

Enter in 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. ZZ should be entered to indicate a Taxonomy Code.

E	F	G DAYS	H EPSDT	I	J

DIAGNOSIS POINTER	$ CHARGES	OR UNITS	Family Plan	ID QUAL	RENDERING PROVIDER ID #
				ZZ	Taxonomy Code
					NPI Rendering Provider NPI ID #

24J. Rendering Provider ID # Required if applicable
(SHADED AREA) – Use for Taxonomy Code Reporting

Use this SHADED field to report the provider's 10 digit alpha-numeric Taxonomy Number.

NOTE: Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer's EOB to the claim.

See Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual for details on billing claims with Medicare and other insurance.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
					NPI Rendering Provider NPI ID #

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

The Rendering Provider's 10 digit NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
				NPI	0000000000

25. Federal Tax ID Number **Required**

Enter the tax ID number and mark the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and mark the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
861234567	☐	☑	

26. Patient's Account Number **Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. AHCCCS 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 **Required**

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

27. ACCEPT ASSIGNMENT? (For govt claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 179 00	29. AMOUNT PAID $	30. BALANCE DUE $

29. Amount Paid **Required if applicable**

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

30. Reserved for NUCC Use **Not required**

31. Signature and Date **Required**

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

<u>The signature may be handwritten, but it must be done in black pen.</u>

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: 03/01/13

32. Service Facility Location Information **Required if applicable**

32a. Service Facility NPI # **Required if applicable**

32b. Service Facility AHCCCS ID # (Shaded Area) **Required if applicable**

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

Arizona Hospital 123 Main Street Phoenix, AZ 85XXX a. NPI | b. AHCCCS ID

33. Billing Provider Name, Address and Phone # 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 # Required if applicable

33b. Other ID – AHCCCS ID # (Shaded Area) Required if applicable

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Doc Holliday 123 OK Corral Drive Tombstone, AZ 85XXX	
a. NPI	b. Taxonomy Code

Revision History

Date	Description of changes	Page(s)
11/23/2018	Clarification added to the following field's on the CMS 1500 form: • 24I – Qualifier ZZ if a Taxonomy Code is entered • 24J – Shaded Section – Taxonomy Code • 24J – Unshaded Section – NPI • 33a – NPI • 33b – Taxonomy Code Note: The previous instruction to include the COB information in the shaded section of 24 J has been removed.	
10/1/2018	Field 21 has been updated to include additional information regarding the necessity for the ICD Indicator to be filled out. The following was removed: "When submitting claims via fax it is recommended to fax in the following order: ADA 2012 claim form first, the Explanation of Benefits (EOB) second (if applicable), and any applicable medical documentation third. "	7 1

	Clarification added to 9a. Clarification added to field 21.	4 7
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	All
7/3/2018	Field 28 was updated. It now reads as: "Enter the total for all charges for all lines on the claim."	14
4/20/2018	Clarifications added regarding the need to have lines 1-6 filled out (under field 24 A-J) in entirety before proceeding to the second page.	2 & 8
3/23/2018	Clarification added to the General Information on the CMS-1500 & Claim Submission section, including that this chapter applies to paper claims only, the preferred font type and size, the preferred methods of claims submissions (HIPAA-Compliant 837 transaction process and AHCCCS Online provider portal), and information on what can make a claim deny. Clarification added to fields 3, 4, 5, and 6. Clarification added to field 12. Clarification added to field 13. 7Field 19 was updated to include a new standard format, that will allow providers to indicate if services were at an FQHC, along with any additional information that may be needed. Clarification added to field 22. Clarification added to field 23. Clarification added to fields 24 A and B (graphs add). Clarification added to field 24D (graph added). Clarification added to field 24 J (graph also added) Multi-page claim clarification added to field 28. Clarification that only ICD-10 codes will be accepted added. Field names matched to the updated CMS-1500 Claim Form version 02/12. Formatting	1-2 3 5 5 6-7 7-8 8 8-9 10 11-13 13-14 All All All
10/15/2015	Correction for fields 17, 17a, 17b, 19 and 24	4, 6
09/14/2015	New format "ICD-9" replaced with "ICD"	All multiple
04/02/2014	Replaced CMS 1500 "08/05" with new version 02/12	multiple