

Form

Revision Dates: 5/31/2023; 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 837P transaction process.

If a provider is not set up to perform the 837P 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 **<u>replacement/voided</u>** claims is via the AHCCCS Online Provider Portal.

For information on how to submit claims using the HIPAA-compliant 837P 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 837P transactions are available on the AHCCCS website at <u>www.azahcccs.gov</u>. The companion documents are intended to supplement, but not replace, the 837P Implementation Guides for the 837P 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 <u>all lines (1-6) under</u> <u>field 24 (A-J) must be completed on the first page, before proceeding to the second</u> <u>page</u> 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 <u>a second page cannot be submitted unless all lines on page 1 are</u> <u>utilized and completely filled in first.</u>

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 scannable Quick Response (QR) code symbol and the date approved by the NUCC.

<u>Effective 4/1/2014</u>, 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

Mark the second box labeled "Medicaid."

MEDICARE MEDICAID		TRICARE	TRICARE CHAMPVA		FECA BLK LUNG	OTHER
□ (Medicar	I (Medicai □	(ID# /	□ (member	□ (<i>ID</i> #)	□ (ID#	□ (ID#
e#)	d#)	DoD#)	ID #)))

1a. Insured's ID Number

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.

Required



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

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

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

3. PAT DATE	IEN	ſ'S BIRTH	SE	Х					
MM DD YY									
01	1	19XX	M 🗵	F□					

4. Insured's Name

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

5. Patient Address

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

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

Not Required

Date of Birth is Required Sex is Required if Applicable

Required

Not Required

Not Required

3 | 1 7



8. Reserved for NUCC Use

9. Other Insured's Name

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

9c. Reserved for NUCC Use

9d. Insurance Plan Name or Program Name

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient's Condition Related to:

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 CON TO:	IDITION RELA	TED
a. EMPLOYMENT? (CI PREVIOUS)	JRRENT OR	
□ YES	🗵 NO	
b. AUTO ACCIDENT? (State)		PLACE
🗷 YES	□ NO AZ	
c. OTHER ACCIDENT	?	
□ YES	🗷 NO	

10d. Claim Codes (Designated by NUCC)

Not Required

4 | 1 7

Required if applicable

Required if applicable

Required if applicable

Not Required

Not Required

Not Required



11.	Insured's Policy Group or FECA Num	ber	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 Nan	ne	Required if applicable
11d.	Is There Another Health Benefit Plan		Required if applicable
	Mark the appropriate box to indicate cov marked, you must complete Fields 9a-	•	CCCS. If "Yes" is
12.	Patient or Authorized Person's Signat	ure	Required
	If the signature is on file, then stating that	the signature is on fil	e is acceptable.
	The signature may be handwritten, but it	must be done in bla	ck pen.
13.	Insured's or Authorized Person's Sign	ature	Required if applicable
	If the member is under 18 years of age member/authorized person. If the signa on file is acceptable.		
	The signature may be handwritten, but	it must be done in bla	ack pen.
14.	Date of Illness, Injury, or Pregnancy (L	.MP)	Required if applicable
15.	Other Date		Not Required
16.	Dates Patient Unable to Work in Curre	ent Occupation	Not Required
17.	Name of Referring Provider or Other S If applicable, enter the Qualifier: DN Referring Provider DK Ordering Provider DQ Supervising Provider	Source	Required if applicable
	Next, enter the name of the provider or o	ther source.	
	The ordering provider is <u>required</u> for: Laboratory Radiology Medical and surgical supplies	Drugs (J-codes) Temporary K and Q Orthotics	codes



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Respiratory DME Enteral and Parenteral Therapy Durable Medical Equipment Chiropractic Services*

Prosthetics Vision codes (V-codes) Diabetes Self-Management*

Ordering provider can be any of the following: M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist, Certified Nurse Midwife, or Clinical Nurse Specialist (limited to DME and prescribing pharmacological agents in specific licensed health care institutions).

*Optometrists, dentists & psychologists would not be acceptable as the ordering provider for these services.

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	aloim (that is not found in

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.



CHAPTER 5 BILLING ON THE CMS 1500 CLAIM FORM

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 <u>ProviderTrainingFFS@azahcccs.gov</u>.

20. Outside Lab and \$ Charges

Required

Not required

21. Diagnosis Codes

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.

21. DIAGNOSIS OR NATURE	E OF ILLNESS OR INJURY Re	late A-L to service line below (24E)	ICD Ind.
A	В.	C.	D
E	F	G.	н
I.	J	К.	L





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.

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

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 <u>all lines (1-6)</u> <u>under field 24 (A-J) must be completed on the first page, before proceeding to</u> <u>the second page</u> 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 <u>a second page</u>

Not required

Required if applicable



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 <u>administered</u> to the patient.

Example: N400074115278 ML10

NDC Unit of Measure:

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

24. A	В	С	D		
DATE(S) OF SERVICE	Place		PROCEDURE, SERVICES, OR		
			SUPPLIES		
From To	of	EM	(Explain Unusual Circumstances)		
		G			
MM DD YY MM DD Y	Servic		CPT/HCPCS MODIFIER		
N	e e				
N400074115278 ML10					
07 01 13 07 01 1	3 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.	А					В	С		D
DATE(S) OF SERVICE						Place		PROCEDURE SUPPLIES	E, SERVICES, OR
From To						of	EM G	(Explain	Unusual Circumstances)
MM	MM DD YY MM DD Y				Y Y	Servic e		CPT/HCPCS	MODIFIER



CHAPTER 5 BILLING ON THE CMS 1500 CLAIM FORM

N	100	07411	15278 N	/IL10						
0		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.	А					В	С		D	
	DATE	(S) OF :	SERVI	CE		Place		PROCEDURE, SERVICES, OR		
								SUPPLIES		
	From		•	То		of	ΕM	(Explain	Unusual Circumstances)	
							G			
MM	DD	ΥY	MM	DD	Υ	Servic		CPT/HCPCS	MODIFIER	
					Υ	е				
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					В	С		D		
DATI	SER	VICE		Place		PROCEDURE SUPPLIES	E, SERVICE	ES, O	R	
Fron	From To					EMG	(Explain Unus			ces)
MM D	D YY	Y MM DD YY			Servic		CPT/HCPCS	MODIFIE	२	
					е					
						Υ				

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			В	С		D			
DATE(S) OF SERVICE			Place		PROCEDURE SUPPLIES	, SEI	RVIC	ES, C)R
From	Т	С	of	EMG					ces)
MM DD YY	MM D	D YY	Servic		CPT/HCPCS	MOE	DIFIE	R	
			е				-	-	-
					71010	26			

24E. Diagnosis Pointer

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the <u>letter</u> of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), <u>not</u> 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	E	F	G	Н
PROCEDURE, SERVICES, OR SUPPLIES			DAYS	EPSDT
(Explain Unusual Circumstances)	DIAGNOSI S	\$ CHARGES	OR	Family
CPT/HCPCS MODIFIER	POINTER		UNITS	Plan
	A			
	AB			

CHAPTER 5 BILLING ON THE CMS 1500 CLAIM FORM

24F. \$ Charges

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	Н
PROCEDURE, SERVICES, OR SUPPLIES			DAYS	EPSDT
(Explain Unusual Circumstances)	DIAGNOSI S	\$ CHARGES	OR	Family
CPT/HCPCS MODIFIER	POINTER		UNITS	Plan
		150 00		
		79 00		

24G. **Days or Units**

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	Н
PROCEDURE, SERVICES, OR SUPPLIES			DAYS	EPSDT
(Explain Unusual Circumstances)	DIAGNOSI S	\$ CHARGES	OR	Family
CPT/HCPCS MODIFIER	CODE		UNITS	Plan
			3	
			1	

24H. EPSDT/Family Planning

241. **ID** Qualifier

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 DAY	H EPSD T	I	J
		5	I		

Required

Required

13 | 1 7

Not required





DIAGNO	\$	OR	Famil	ID	RENDERING
SIS	CHARGES		у	QUA	PROVIDER
POINTER		UNIT S	Plan	L	ID#
				ZZ	Taxonomy Code
					NPI Rendering Provider NPI ID #

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

Required if applicable

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 DIAGNO SIS POINTER	F \$ CHARGES	G DAY S OR UNIT S	H EPSD T Famil y Plan	I QUA L	J RENDERING PROVIDER ID #
					Taxonomy Code
					NPI Rendering Provider NPI ID #

24J. Rendering Provider ID # (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	F	G	Н	I	J
		DAY	EPSD		
	•	S	_ T		
DIAGNO	\$	OR	Famil	ID	RENDERING
SIS	CHARGES		У	QUA	PROVIDER
				L	
POINTER		UNIT	Plan		ID #
		S			
					Taxonomy Code
				NPI	000000000

25. Federal Tax ID Number

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		\checkmark	

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

28. Total Charge

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

Required

Not required

Required

15 | 1 7



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

29. Amount Paid

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

Required

Required if applicable

31. Signature and Date

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.

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

	NATURE OF P	HYSICIA	NOR
SUPPLII INC	=R LUDING DEGI	REE OR	
CREDE			
•	fy that the stat o this bill and a		
SIGNE D	John Doe	DAT E	03/01/13

32. Service Facility Location Information

- 32a. Service Facility NPI #
- 32b. Service Facility AHCCCS ID # (Shaded Area)

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

Required if applicable

Required if applicable



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Arizona Hospital 123 Main Street Phoenix, AZ 85XXX

a. NPI | b. AHCCCS ID

33. Billing Provider Name, Address and Phone

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

Required if applicable

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

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

Revision History

Date	Description of changes	Page(s)
5/31/23	Added Diabetes Self-Management and Chiropractic Services to services requiring an ordering provider.	5-6



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



CHAPTER 5 BILLING ON THE CMS 1500 CLAIM FORM

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	Clarification added to 9a.	4
7/40/0040	Clarification added to field 21.	
7/10/2018	The request for there to be no handwriting on claims was rescinded	All
	and the chapter was updated throughout to remove references to 'no	
	handwriting on claims.' Handwriting (legible) may be permitted.	
7/3/2018	Field 28 was updated. It now reads as:	14
	"Enter the total for all charges for all lines on the claim."	
4/20/2018	Clarifications added regarding the need to have lines 1-6 filled out	2&8
	(under field 24 A-J) in entirety before proceeding to the second page.	
3/23/2018	Clarification added to the General Information on the CMS-1500 &	1-2
	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.	3
	Clarification added to field 12.	5
	Clarification added to field 13.	5
	7Field 19 was updated to include a new standard format, that will	6-7
	allow providers to indicate if services were at an FQHC, along with	0.
	any additional information that may be needed.	
	Clarification added to field 22.	7-8
	Clarification added to field 23.	8
	Clarification added to field 23. Clarification added to fields 24 A and B (graphs add).	8-9
		10
	Clarification added to field 24D (graph added).	11-13
	Clarification added to field 24 J (graph also added)	
	Multi-page claim clarification added to field 28.	13-14
	Clarification that only ICD-10 codes will be accepted added.	All
	Field names matched to the updated CMS-1500 Claim Form version	All
	02/12.	All
	Formatting	
10/15/2015	Correction for fields 17, 17a, 17b, 19 and 24	4,6
09/14/2015	New format	All
	"ICD-9" replaced with "ICD"	multiple
		-
04/02/2014	Replaced CMS 1500 "08/05" with new version 02/12	multiple
		-