Instructions for Completing a CMS 1500 Form

See a sample of the CMS 1500 Claim Form and additional information on Provider Connection at https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/claims/policies_guidelines/claim_forms_guidelines.

Block #	Instructions
1	**Insurance Coverage** Indicate the type of health insurance coverage applicable by placing an X in the appropriate box.
1a	**Insured's ID Number** Enter the subscriber's ID number exactly as on their ID card, including the first three alpha-numeric characters.
2	**Patient's Name** Enter the patient's full last name, first name, and middle initial exactly as on their ID card. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
3	**Patient's Birth Date, Sex** Enter the patient's 8-digit birth date (MM/DD/YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. If sex is unknown, leave blank.
4	**Insured's Name** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt., Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	**Patient's Address** Enter patient's complete current address including street address, city, state, and zip code.
6	**Patient Relationship to Insured** Enter an X in the correct box to indicate the patient's relationship to insured.
7	**Insured's Address** Enter insured subscriber's complete address including street address, city, state, and zip code.
8	**Reserved for NUCC Use** Leave blank.

9 **Other Insured's Name**
If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the other insured enrollee's full last name, first name and middle initial.

9a **Other Insured's Policy or Group Number**
Enter the policy or group number of the other insured.

9b **Reserved for NUCC Use**
Leave blank.

9c **Reserved for NUCC Use**
Leave blank.

9d **Insurance Plan Name or Program Name**
Enter the other insured's insurance plan or program name.

10a-c **Is Patient's Condition Related To:**
When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.

10d **Claim Codes (Designated by NUCC)**
When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC.

11 **Insured's Policy, Group, or FECA Number**
Enter the insured's policy or group number as it appears on the insured's health care identification card.

11a **Insured's Date of Birth, Sex**
Enter the 8-digit date of birth (MM/DD/YYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

11b **Other Claim ID (Designated by NUCC)**
Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
When submitting to Property and Casualty payers, e.g., Automobile, Homeowner's, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:
Y4 Agency Claim Number (Property Casualty Claim Number)

11c **Insurance Plan Name or Program Name**
Enter the name of the insurance plan or program of the insured.

11d **Is there another Health Benefit Plan?**
When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d with other health benefit plan information.

12 **Patient's or Authorized Person's Signature**
Not applicable.

Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals.

13 **Insured's or Authorized Person's Signature**
Not applicable.

Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals

14 **Date of Current Illness, Injury or Pregnancy (LMP)**
Enter the 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.
Enter the applicable qualifier to identify which date is being reported.
- 431 Onset of Current Symptoms or Illness
- 484 Last Menstrual Period

15 **Other Date**
If applicable, enter another date related to the patient's condition or treatment.
Enter the date in the 8-digit (MM/DD/YYYY) format.
Enter the applicable qualifier to identify which date is being reported.
- 454 Initial Treatment
- 304 Latest Visit or Consultation
- 453 Acute Manifestation of a Chronic Condition
- 439 Accident
- 455 Last X-ray
- 471 Prescription
- 090 Report Start (Assumed Care Date)
- 091 Report End (Relinquished Care Date) 4
- 444 First Visit or Consultation

16 **Dates Patient Unable to Work in Current Occupation**
If the patient is employed and is unable to work in current occupation, an 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

17 **Name of Referring Provider or Other Source**
Enter the name first name, middle initial, last name followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words "self-referral."

17a **Other ID#**
The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

0B State License Number
1G Provider UPIN Number
G2 Provider Commercial Number
LU Location Number (This qualifier is used for Supervising Provider only.)

17b **NPI #**
Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

18 **Hospitalization Dates Related to Current Services**
Complete these dates when a medical service is furnished as a result of, or subsequent to, a related hospitalization. Enter the inpatient 8-digit (MM/DD/YYYY) hospital admission date followed by the 8-digit (MM/DD/YYYY)

discharge date (if discharge has occurred). If not discharged, leave discharge date blank.

19 **Additional Claim Information (Designated by NUCC)**
Use this to identify additional information about the patient's condition or the claim.

20 **Outside Lab? $Charges**
Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider. A "NO" mark or blank indicates that no purchased services are included on the claim. If "YES" is marked, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.
When lab procedures are performed by a party other than the billing physician/lab, identify procedures by adding the -90 modifier to the regular procedure code in Block 24D. Charges for these services cannot exceed the amount the outside laboratory charged.

21 **Diagnosis or Nature of Illness or Injury**
List no more than 12 ICD-10 CM codes in priority order with the primary diagnosis in the #1 position. Do not add any diagnosis description.

22 **Resubmission and/or Original Reference Number**
Not applicable.

23 **Prior Authorization Number**
Enter authorization number from Blue Shield or member's group (IPA), when applicable.

24 **Itemized Services**
Itemize each service rendered using the appropriate codes. Report only one service per line. This area of the claim form may not contain more than six lines of service. If you need to report more lines for the same patient, do so on separate claims. Also, claims cannot be continued from one to another; each claim must be separate.

24a **Date(s) of Service**
Enter the month, day, and year for each procedure, using the format "MMDDYY." For non-DME and radiation treatment leave 'to' date blank - no date ranging.

Durable Medical Equipment & Radiation Treatment Dates: Enter the month, day, and year for each procedure using the format "MMDDYY." Report all services provided on the same day for the same patient using only one claim

form to ensure correct benefit coverage. Monthly rentals must be coded with a date span. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24b **Place of Service**
Enter the two-digit Place of Service code. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
Refer to the Medicare website www.cms.gov for current place of services.

24c **EMG**
Leave blank. Completion of this block is not required.

24d **Procedures, Services, or Supplies**
Enter procedure, service or supply using the appropriate HCPCS/CPT procedure code and up to four modifiers. For assistant at surgery or anesthesia, always be sure to include applicable modifiers. For Telehealth HIPAA compliant video services, use Modifier 95 in 24d and place of service 02 in 24b.

Note: When you need to use more than four modifiers with a procedure code, enter Modifier 99 in Block 24D and list applicable modifiers in Block 19.

To report bi-lateral procedures, the services must be billed on two lines of the submitted claim. For example:

19368
19368-50

24e **Diagnosis Pointer**
Enter diagnosis code reference pointer from Block 21 to relate date of service and procedures performed to appropriate diagnosis. Place commas between multiple diagnosis reference pointers on the same line.

24f **Charges**
Enter the charge amount for the service performed. Do not enter dollar signs or decimal points. Always include cents.

24g **Days or Units**
Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

Anesthesia services must be reported as minutes. Units may only be reported for

anesthesia services when the code description includes a time period (such as "daily management").

DME monthly rentals must be coded with 30 units and accompanying date span. See 24a Date(s) of Service for more information.

24h **EPSDT/Family Plan**
Not applicable.

24i **ID Qualifier**
Enter in the shaded area of 24I the ZZ qualifier identifying the rendering provider Taxonomy number. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

24j **Rendering Provider ID #**
Enter the provider specialty Taxonomy Code (in the shaded area) and NPI (in the non-shaded area) for the performing or rendering provider or supplier.

Provider organizations such as medical group practices or clinics must include the rendering provider taxonomy code and the NPI of the rendering provider. Providers who bill as individual practitioners should also include on their claims the rendering provider specialty taxonomy code and the rendering provider NPI.

Note: Claims from group practices submitted without the rendering specialty taxonomy code in Block 24j will be rejected.

Enter provider specialty taxonomy code and NPI of the rendering provider or supplier. Several different providers or suppliers may be involved in providing services billed on the claim. If several members of a group shown in Block 33 have furnished services, this item is used to distinguish them.

25 **Federal Tax ID Number**
Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider.

26 **Patient's Account No.**
Enter the patient's account number.

27 **Accept Assignment?**
Enter an X in the correct box to report "Accept Assignment" for all payors.

28 **Total Charge**
Enter the amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

29 **Amount Paid**
Enter total amount paid by patient on submitted charges in Block 28.

30 **Reserved for NUCC Use**
Leave blank.

31 **Signature of Physician or Supplier Including Degrees or Credentials**
Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM/DD/YYY), 8-digit date (MM/DD/YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

32 **Service Facility Location Information**
Enter name and full address including the street number, city, state, and zip code of person, organization or facility performing services, if services were furnished in a hospital, clinic, laboratory, or any facility other than patient's home or provider's office. For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented or purchased at a retail store.

32a **NPI#**
Enter the NPI number of the service facility location in 32a.

32b **Other ID#**
Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number.

33 **Billing Provider Info & Ph #**
Enter the provider's or supplier's billing name, full address including the street number, city, state, zip code and phone number.

33a **NPI#**
Enter the NPI number of the billing provider or supplier

33b **Other ID#**
Enter the taxonomy code of the billing provider or supplier.