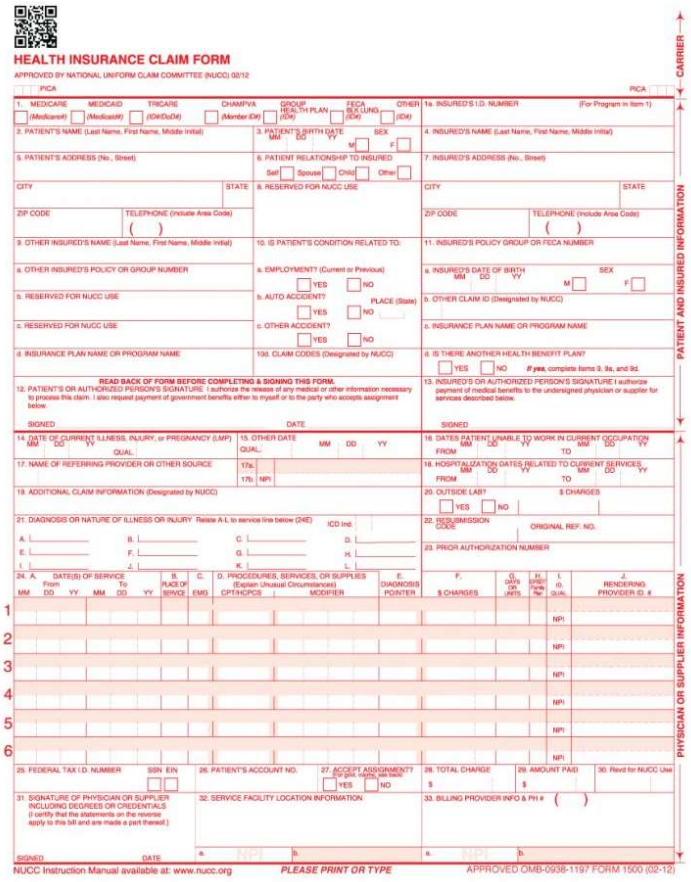
How To Complete a CMS 1500 Medical Claim Form for Dentistry

- Laurie Owens CPC, CPB

When billing medical insurance, electronic claims are the preferred way to submit a claim. Electronic claims are superior because they ensure correct processing, faster submission to the insurance, and they decrease errors on claims.

Tools like Imagn Billing are helpful because they submit your case according to what the insurance requires. You simply input your case information in one easy straightforward place and never worry about using the CMS 1500 form. With the case audit system built into Imagn Billing, you won't accidentally submit a medical claim with missing information. The reason medical insurance claims sent by dental providers are denied is because of missing information about 90% of the time.


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Using the Correct Form

To submit the CMS 1500 form correctly you first must purchase them online. The CMS 1500 claim form uses a unique ink that allows the form to be scanned quickly and because of that, the blank CMS 1500 form cannot be handwritten or printed by you. If you send a CMS 1500 claim form that you did not purchase, but printed yourself, it will be denied. This is another reason that it is better to submit electronically.

If you find yourself in a position where you need to complete a CMS 1500 form it can seem daunting. The National Uniform Claim Committee (NUCC) releases the 1500 Health Insurance Claim Form Reference Instruction Manual for the CMS 1500 form and updates it regularly. This post was created using the 8.0 7/20 version. But we thought that we could make it a little easier to navigate.
There are some formatting rules that you must remember. Type everything in ALL CAPS. Insurance prefers it to be formatted this way and by doing so you will avoid any petty denials.

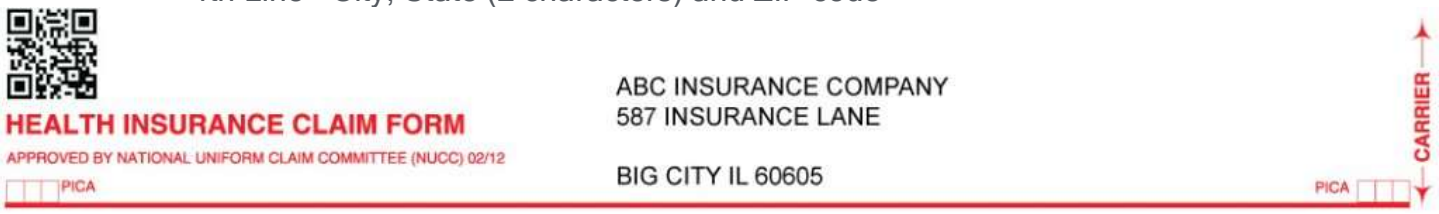
Multiple Page Claims

When reporting line-item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim. If there are more than 50 service lines, the claim must be split.

Header Insurance Information

The insurance address in the header. Here are examples of how insurance wants their address to be listed. If the insurance has a PO Box you will leave the third line blank and put the city, state, and zip code on the fourth line.

- 1st Line – Name
- 2nd Line – First line of address
- 3rd Line – Second line of address, if necessary
- 4th Line – City, State (2 characters) and ZIP code



For an address with three lines, enter it in the following format:

- 1st Line – Name
- 2nd Line – Line of address
- 3rd Line – Leave blank
- 4th Line – City, State (2 characters) and ZIP code

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

Box 1 & 1a: Type of Insurance & ID#

Box 1

Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other" means the insurance type to which the claim is being submitted. "Other" indicates health insurance including HMOs, commercial insurance, automobile accident, liability, or workers' compensation. This information directs the claim to the correct program and may establish primary liability.

Box 1a

Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. If the patient has a unique Member Identification Number assigned by the payer, then enter that number in this field.

FOR TRICARE

Enter the DoD Benefits Number (DBN 11-digit number) from the back of the ID card.

FOR WORKERS COMPENSATION CLAIMS

Enter the appropriate identifier of the employee.

FOR OTHER PROPERTY AND CASUALTY CLAIMS

Enter the appropriate identifier of the insured person or entity.

Box 2: Patient's Name - Required

Enter the member's name as is indicated on their Insurance card. Enter the patient's full last name, first name, and middle initial. If the patient 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.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name. If the patient's name is the same as the insured's name (i.e., the patient is the insured), then it is not necessary to report the patient's name.

Box 3: Patient's Date of Birth - Required

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. Only one box can be marked. If sex is unknown, leave blank.

Box 4: Name of Insured - If Applicable

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. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

FOR WORKERS COMPENSATION CLAIMS

Enter the name of the Employer.

FOR OTHER PROPERTY & CASUALTY CLAIMS

Enter the name of the insured person or entity.

Box 5: Patient's Address - Required

Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions. If the patient's address is the same as the insured's address, then it is not necessary to report the patient's address. "Patient's Telephone" does not exist in 5010A1. The NUCC recommends that the phone number not be reported. Phone extensions are not supported.

FOR WORKERS' COMPENSATION AND OTHER PROPERTY AND CASUALTY CLAIMS

If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

Box 6: Patient's Relationship to Insured - If Applicable

Enter an X in the correct box to indicate the patient's relationship to insured when Item Number 4 is completed. Only one box can be marked. If the patient is a dependent but has a unique Member Identification Number and the payer requires the identification number be reported on the claim, then report "Self", since the patient is reported as the insured.

The "Patient Relationship to Insured" indicates how the patient is related to the insured. "Self" would indicate that the insured is the patient. "Spouse" would indicate that the patient is the husband or wife or qualified partner, as defined by the insured's plan. "Child" would indicate that the patient is the minor dependent, as defined by the insured's plan. "Other" would indicate that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured's plan.

Box 7: Insured Address

Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

FOR WORKERS COMPENSATION CLAIMS

Enter the address of the Employer.

FOR OTHER PROPERTY AND CASUALTY CLAIMS

Enter the address of the insured noted in Item Number 4.

Box 8: Reserved for NUCC USE

This field was previously used to report “Patient Status.” “Patient Status” does not exist in 5010A1, so this field has been eliminated. This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

Box 9 (a,b,c,d): Other Insured Name

If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured’s full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. 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. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

9a – Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number.

9b – This field was previously used to report “Other Insured’s Date of Birth, Sex.” “Other Insured’s Date of Birth, Sex” does not exist in 5010A1, so this field has been eliminated. This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

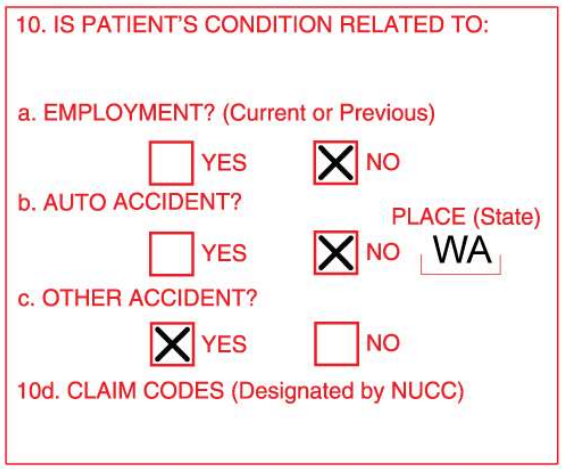
9c – This field was previously used to report “Employer’s Name or School Name.” “Employer’s Name or School Name” does not exist in 5010A1, so this field has been eliminated. This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

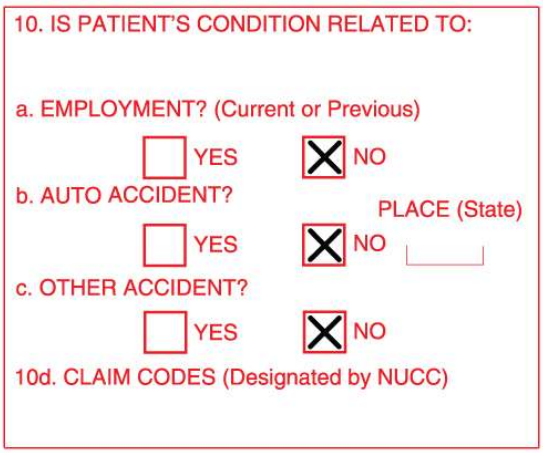
Box 10 (a,b,c,d): Is Patients Condition Related To

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. Primary insurance information must then be shown in Item Number 11.

This information indicates whether the patient’s illness or injury is related to employment, auto accident, or other accident. “Employment (current or previous)” would indicate that the condition is related to the patient’s job or workplace. “Auto accident” would indicate that the condition is the result of an automobile accident. “Other accident” would indicate that the condition is the result of any other type of accident.

Here are two samples. On the left is how a claim should look if there was an accident. Be sure to list the state if you check yes for A, B, or C. On the right is how your claim should look if there is no trauma involved.





Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these situations). Note: Do not use Condition Codes when submitting a revised or corrected bill.

The following is the list of Condition Codes for worker's compensation claims that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

W2 Duplicate of original bill
W3 Level 1 appeal
W4 Level 2 appeal
W5 Level 3 appeal

Box 11 (a,b,c,d): Insured Policy Group or FECA Number

Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed. Do not use a hyphen or space as a separator within the policy or group number.

11A-B

Name, Policy/Group Number, Employer/School Name, Insurance Plan/Program Name

11C – If Applicable

For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.

11D – Required

If the patient has secondary MEDICAL insurance, that is the only time you would check yes. If yes then complete boxes 9, 9a, and 9d. Dental insurance is not secondary medical insurance.

Box 12 & 13: Patient's or Authorized Signature

Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File."

The “Patient’s or Authorized Person’s Signature” indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

13 – Enter “Signature on File,” “SOF,” or legal signature. If there is no signature on file, leave blank or enter “No Signature on File.”

Box 14: Date of Current Illness, Injury, or Pregnancy (LMP) – Required

Date of Current – Illness (First Symptom) OR Injury OR Pregnancy (LMP) – Enter the date of onset of the member’s illness, the date of accident/injury or the date of the last menstrual period.

Box 15: Other Date

Enter another date related to the patient’s condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 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)
- 444 First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

Box 16: Dates Patient Unable to Work in Current Occupation

If the patient is employed and is unable to work in current occupation, a 6-digit (MM | DD | YY) or 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.

Box 17: Name of Referring Provider or Other Source – If Applicable

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		
DN	MICHAEL STEVENSON MD	17b.	NPI	1234567890

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 Enter the qualifier to the left of the vertical, dotted line.

17A – If Applicable

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 – If Applicable

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

Box 18: Hospitalization Dates Related to Current Service - If Applicable

Hospitalization Dates Related to Current Services – Enter the date of hospital admission and discharge if the services billed are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.

Box 19: Additional Claim Information - If Applicable

Please refer to the most current instructions from the public or private payer regarding the use of this field. Report the appropriate qualifier, when available, for the information being entered. Do not enter a space, hyphen, or other separator between the qualifier and the information. For the Claim Information (NTE), the following are the qualifiers in 5010A1. Enter the qualifier “NTE”, followed by the appropriate qualifier, then the information. Do not enter spaces between the qualifier and the first word of the information. After the qualifier, use spaces to separate any words.

- ADD Additional Information
- CER Certification Narrative
- DCP Goals, Rehabilitation Potential, or Discharge Plans
- DGN Diagnosis Description
- TPO Third Party Organization Notes

For additional identifiers (REFs), the following are the qualifiers in 5010A1. Enter the qualifier “REF”, followed by the qualifier, then the identifier. Do not enter spaces between the qualifier and identifier.

- 0B State License Number
- 1G Provider UPIN Number
- G2 Provider Commercial Number
- LU Location Number (This qualifier is used for Supervising Provider only.)
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The social security number may not be used for Medicare.)

- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. Taxonomy codes or other identifiers reported in this field must not be reportable in other fields, i.e., Item Numbers 17, 24J, 32, or 33.

For Supplemental Claim Information (PWK), the following are the qualifiers in the 5010A1. Enter the qualifier “PWK”, followed by the appropriate Report Type Code, the appropriate Transmission Type Code, then the Attachment Control Number. Do not enter spaces between the qualifiers and data.

- 03 Report Justifying Treatment Beyond Utilization
- 04 Drugs Administered
- 05 Treatment Diagnosis
- 06 Initial Assessment
- 07 Functional Goals
- 08 Plan of Treatment
- 09 Progress Report
- 10 Continued Treatment
- 11 Chemical Analysis
- 13 Certified Test Report
- 15 Justification for Admission
- 21 Recovery Plan
- A3 Allergies/Sensitivities Document
- A4 Autopsy Report
- AM Ambulance Certification
- AS Admission Summary
- B2 Prescription
- B3 Physician Order
- B4 Referral Form
- BR Benchmark Testing Results Version 8.0 7/20 30
- BS Baseline BT Blanket Test Results
- CB Chiropractic Justification
- CK Consent Form(s)
- CT Certification
- D2 Drug Profile Document
- DA Dental Models
- DB Durable Medical Equipment Prescription
- DG Diagnostic Report
- DJ Discharge Monitoring Report
- DS Discharge Summary
- EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
- HC Health Certificate
- HR Health Clinic Records
- I5 Immunization Record
- IR State School Immunization Records
- LA Laboratory Results

- M1 Medical Record Attachment
- MT Models
- NN Nursing Notes
- OB Operative Note
- OC Oxygen Content Averaging Report
- OD Orders and Treatments Document
- OE Objective Physical Examination (including vital signs) Document
- OX Oxygen Therapy Certification
- OZ Support Data for Claim
- P4 Pathology Report
- P5 Patient Medical History Document
- PE Parenteral or Enteral Certification
- PN Physical Therapy Notes
- PO Prosthetics or Orthotic Certification
- PQ Paramedical Results
- PY Physician's Report
- PZ Physical Therapy Certification
- RB Radiology Films
- RR Radiology Reports
- RT Report of Tests and Analysis Report
- RX Renewable Oxygen Content Averaging Report
- SG Symptoms Document
- V5 Death Notification XP Photographs

Box 20: Additional Claim Information - If Applicable

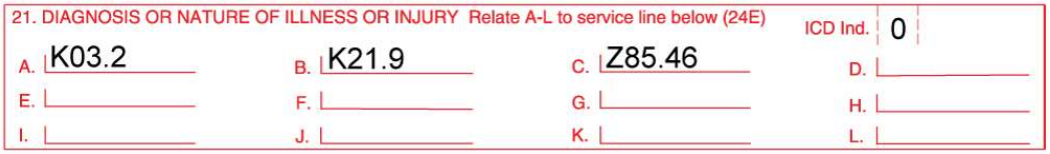
Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased 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 entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

Box 21: Diagnosis or Nature of Illness or Injury - Required

Diagnosis or Nature of Illness or Injury – Enter all letters and/or numbers of the ICD-10 code for each diagnosis, including fourth and fifth digits if present. The first diagnosis listed in section 21.1 indicates the primary reason for the service provided. Make sure that you put a 0 in the box next to ICD IND. This informs the insurance that you used ICD-10 diagnosis codes.



Box 22 & 23: Prior Authorization Number

22 – Prior Resubmission Code

List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field. When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

- 7 Replacement of prior claim
- 8 Void/cancel of prior claim

23 – Prior Authorization Number - If Applicable

If you have a prior authorization number, place it in box 23. Prior authorization will enable quick processing of your claim. When using Imagn Billing, prior authorizations can be seamlessly added to claims in seconds. Do not enter hyphens or spaces within the number.

Box 24: Code Sequencing - Required

Qualifiers above service lines. For miscellaneous codes (41899 extractions and crowns or 21089 implant crowns) must have a qualifier above the service line (see above line 3). If you are doing Botox, Arestin, or other medication billing, you must list the NDC number above the service line. The NDC number will be listed on your medication packaging and will always start above the claim with an N.

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- ZZ Narrative description of unspecified code
- JP Universal/National Tooth Designation System

The following are the codes for areas of the oral cavity, reported with the JO qualifier:

- 00 Entire oral cavity
- 01 Maxillary arch
- 02 Mandibular arch
- 10 Upper right quadrant
- 20 Upper left quadrant
- 30 Lower left quadrant
- 40 Lower right quadrant

	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	10	10	20	10	10	20	11	Y	41005		A	400 00	2		NPI	123456789
2	10	10	20	10	10	20	11	Y	21210		A	400 00	1		NPI	123456789
3									ZZ D7210 JP 10							
	10	10	20	10	10	20	11	Y	41899		A	250 00	1		NPI	123456789
4	10	10	20	10	10	20	11	Y	99203	25	A	125 00	1		NPI	123456789
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

The following examples are of how to enter different types of supplemental information in 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services.

24A – Dates of Service - Required

Dates of Service – Enter the date the service was rendered in the “from” and “to” boxes in the MMDDYY format. If services were provided on only one date, they will be indicated only in the “from” column. If the services were provided on multiple dates (i.e., DME rental, hemodialysis management, radiation therapy, etc.), the range of dates and number of services should be indicated. “To” date should never be greater than the date the claim is received by the Health Plan.

24B – Place of Service - Required

There is a large list of code for this section but in dentistry, commonly in dentistry we use place of service:

- 11 – Office Visit
- 12 – Home
- 22 – Outpatient Hospital

24C – Emergency Indicator

Checkbox and attach the required documentation.

24D – Procedures, Services or Supplies - Required

Enter the applicable CPT and/or HCPCS National codes in this section. Modifiers, when applicable, are listed to the right of the primary code under the column marked “modifier”. If the item is a medical supply, enter the two-digit manufacturer code in the modifier area after the five-digit medical supply code.

24E- Diagnosis Pointer - Required

Enter the diagnosis code number from box 21 that applies to the procedure code indicated in 24D.

24F – Charges - Required

Enter the charge for service in dollar amount format. If the item is a taxable medical supply, include the applicable state and county sales tax. When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

24G – Days or Units - Required

Enter the number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc. Do not enter a decimal point or leading zeroes. Do not leave blank as units should be at least 1.

24H – EPSDT Family Plan - If Applicable

Enter code “1” or “2” if the services rendered are related to family planning (FP). Enter code “3” if the services rendered are Child Health and Disability Prevention (CHDP) screening related.

24I – ID Qualifier - If Applicable

Enter “X” if billing for emergency services.

24J – Rendering Provider ID# - If Applicable

Enter the Rendering Provider’s NPI number

Box 25: Federal Tax I.D. Number - Required

Enter the “Federal Tax ID Number” (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Do not enter hyphens with numbers. Enter numbers left justified in the field.

Box 26: Patients Account No. - Suggested

While the patient’s account number is a required data element in the 837P claim transaction, it is strongly encouraged but not required on a paper claim. Payers or their vendors may choose to enter a default into the field if no number is reported by the provider for reporting in the 835 remittance. If no default number is used within the internal processing system, payers would report a single zero on an 835 remittance per the 835 TR3.

In this field, you can enter the patient’s chart number or account number. This will then be reflected on the Explanation of Benefits (EOB) if populated.

Box 27: Accept Assignment

If you want the check sent to you, mark yes. If you mark no, the check, correspondence, and EOB will go to the patient and you will not be allowed to follow up on the claim.

Box 28, 29, 30: Payment Totals

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.

28 – Total Charges - Required

Enter the total for all services in dollar and cents. Do not include decimals. Do not leave blank. If you are billing medical and have not billed or collected from another insurance, only complete box 28.

29 – Amount Paid - If Applicable

Enter the amount right justified in the left-hand area of the field, this is ONLY what another insurance has paid. Do not use commas when reporting dollar amounts. Negative dollar amounts are not

allowed. Dollar signs should not be entered. Enter 00 in the right-hand area if the amount is a whole number.
Enter the amount of payment received from the Other Health Coverage. Enter the full dollar amount and cents. Do not enter Medicare payments in this box. Do not enter decimals. If you billed to dental first and they paid, you will list the amount paid in box 29 and the remainder to be paid in box 30.

30 – Rsvd For NUCC Use - If Applicable

This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

Box 31: Signature of Physician or Supplier Including Degrees or Credentials - Required

"Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1. 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|YY), 8-digit date (MM|DD|YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

The claims must be signed and dated by the provider or a representative assigned by the provider in a black pen. An original signature is required. Stamps, initials, or facsimiles are not acceptable.

Box 32 (a,b) Service Facility Location Information:

Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier.

If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.
Enter the name and address information in the following format:

1. Line – Name
2. Line – Address
3. Line – City, State and ZIP code

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

32-a: Service Facility Location Information - Required

Enter the 10-digit NPI number. The NPI number refers to the HIPPA National Provider Identifier number.

32-b: Service Facility Location Information - If Applicable

Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separators between the qualifier and number.

The NUCC defines the following qualifiers use in 5010A1:

- 0B State License Number
- G2 Provider Commercial Number
- LU Location Number

Box 33 (a,b) Billing Provider Info & Phone # (Pay-To) - Required
Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1. Line – Name
2. Line – Address
3. Line – City, State and ZIP code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen. Do not use a hyphen or space as a separator within the telephone number.
If reporting a foreign address, contact payer for specific reporting instructions. 5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.

33-a: Billing Provider Info & Phone # (Pay-To) - Required

Enter the NPI number of the billing provider in 33a. The NPI number refers to the HIPAA National

Provider Identifier number.

33-b: Billing Provider Info & Phone # (Pay-To) - Required
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.

The NUCC defines the following qualifiers used in 5010A1:

- 0B State License Number
- G2 Provider Commercial Number
- ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

References
Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Health Care Claim: Professional (837), 005010X222. Washington Publishing Company, May 2006.
Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Type 1 Errata to Health Care Claim: Professional (837), 005010X222A1. Washington Publishing Company, June 2010.

Laurie Owens CPC, CPB

As the Director of Medical Billing Education for Devdent, Laurie brings over a decade of experience educating dental practices on billing medical insurance and the techniques to get claims paid. Laurie believes that patients should be able to utilize their medical insurance for procedures due to oral systemic conditions.