Provider Notification

Form 1500 (02-12) – Form Completion Instructions

Date of Notification	April 1, 2014	Revision Date	N/A
Plans Affected	All Lines of Business		

INTRODUCTION

The CMS-1500 health insurance claim form has been revised to the 1500 (02/12) version. In the new version, the 1500 symbol at the top left corner has been replaced with a scan-able Quick Response (QR) code symbol with the date approved by the NUCC. Per CMS guidelines, the form went into effect on January 1, 2014 and as of April 1, 2014, instruction was given that this would be the only acceptable form to be submitted. Mercy Care has agreed to allow providers up until July 1, 2014 to bill on the old form, but recommend transition as soon as possible. At that time, claims received after July 1, 2014, regardless of the date of service, will be denied until billed on the new 1500 (02-12) form.

Some of the changes include:

- Changing of some field names to better reflect use.
- Changing of some field names due to 837P electronic submission of claims.
- Changing of some field names that are now reserved for NUCC use.
- Updating diagnosis code field to allow for up to 12 diagnoses and to accommodate ICD-10 alpha/numeric characters and the length of the codes.
- Removed decimal points.

The 1500 (02-12) claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the 1500 (02-12).

1. CPT and HCPCS procedure codes must be used to identify all services.
2. ICD-9 diagnosis codes are required currently. Once the industry switches to ICD-10, then ICD-10 must be used. Based on recent legislation passed, this is currently set for October 1, 2015. DSM-4 diagnosis codes are not accepted and behavioral health services billed with DSM-4 diagnosis codes will be denied.
3. Total charges of claims more than 6 lines should only be billed on the last page when billing a paper claim.

COMPLETING THE REVISED CMS 1500 CLAIM FORM (02/12)

The following instructions explain how to complete the paper 1500 (02-12) claim form and whether a field is "Required," "Required if applicable," or "Not required."

NOTE: This instruction applies to paper 1500 (02-14) claims submitted to Mercy Care Plan, Mercy Care Long Term Care and Mercy Care Advantage.

In the white, open carrier area please provide the name and address of Mercy Care, to whom this claim is being sent. Enter the name and address information in the following format:

1st Line – Name
2nd Line – First line of address
3rd Line – Second line of address, if necessary (if not, leave blank)
4th Line – City State (2 characters) and zip code

Do not use punctuation except for the 9-digit zip code (include the hyphen).

1. Program Block — Required

Check the second box labeled "Medicaid".

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a Insured's ID Number (For program in Item 1)
☐ *(Medicare #)*	☒ *(Medicaid #)*	☐ *(ID#/DoD #)*	☐ *(Member #)*	☐ *(ID #)*	☐ *(ID #)*	☐ *(ID #)*	

1a. Insured's ID Number — Required

Enter the recipient's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit or check eligibility at **www.MercyCarePlan.com**. Behavioral health providers must be sure to enter the member's AHCCCS ID number, *not* the member's BHS number.

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	**1a Insured's ID Number (For program in Item 1)**
☐ *(Medicare #)*	☒ *(Medicaid #)*	☐ *(ID#/DoD #)*	☐ *(Member #)*	☐ *(ID #)*	☐ *(ID #)*	☐ *(ID #)*	**A12345678**

2. Patient's Name — Required

Enter member's last name, first name, and middle initial as shown on the AHCCCS ID card. Commas can be used to separate last name, first name and middle initial but do not use periods.

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 Patient's Date of Birth / Sex	4 PATIENT'S NAME (Last Name, First Name, Middle Initial)	
Holliday, John H		MM DD YY M ☐ F ☐		
5 PATIENT'S ADDRESS (No., Street)		6 PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	5 INSURED ADDRESS (No., Street)	
CITY	STATE		CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )		ZIP CODE	TELEPHONE (Include Area Code) ( )

3. Patient's Date of Birth and Sex — Required

Enter the member's date of birth. Check the appropriate box to indicate the patient's gender.

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		**3 Patient's Date of Birth** / **Sex**	4 PATIENT'S NAME (Last Name, First Name, Middle Initial)	
Holliday, John H		**MM 08 DD 10 YY 51** M ☒ F ☐		
5 PATIENT'S ADDRESS (No., Street)		6 PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7 INSURED ADDRESS (No., Street)	
CITY	STATE	8 RESERVED FOR NUCC USE	CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )		ZIP CODE	TELEPHONE (Include Area Code) ( )

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

5. Patient Address **Not required**

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

7. Insured's Address **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 Mercy Maricopa, 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 group number of the other insurance.

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**

Check "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.

9 OTHER INSURED NAME (Last Name, First Name, Middle Initial	IS PATIENT'S CONDITION RELATED TO:	11 INSURED 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 SEX MM DD YY M ☐ F ☐
b RESERVED FOR NUCC USE	**b AUTO ACCIDENT?** ☐ YES ☒ NO **STATE**	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	d CLAIM CODES (Designated by NUCC)	d IS THERE ANYOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return and complete item 9 a-d

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

11. Insured's Group Policy 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**
Check the appropriate box to indicate coverage other than Mercy Care. If "Yes" is checked, you must complete Fields 9a-d.

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

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

14. Date of Illness or Injury **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**
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. Do not use periods or commas.

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 providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.

17a. ID Number of Referring Provider **Not required**

17b. NPI # of Referring Provider **Required if applicable**

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

19. Reserved for Local Use **Not required**

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

21. Diagnosis Codes **Required**
ICD Ind – Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
9 - ICD-9
0 - ICD-10 (which is required as of 10-01-2015)

Enter at least one *ICD-9 diagnosis code* describing the recipient'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.

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Related A-L to service line below (24E)			ICD Ind	9
A. 998.59	B. 780.6	C.	D.	
E.	F.	G.	H.	
I.	J.	K.	L.	

22. Medicaid Resubmission Code **Required if applicable**

Enter the appropriate code ("A" or "V").

A - Resubmission of a denied claim or an adjustment of a paid claim
V - Void of a paid claim

Enter the claim number of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No".

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO
A or V	**130010004321**

23. Prior Authorization Number **Not required**

The claims system automatically searches for the appropriate authorization for services that require authorization.

24. The shaded area is supplemental information and it can only be entered with a corresponding, completed service line.

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	

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

Enter the beginning and ending service dates.

24 . A. DATES OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURE, SERVICE OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
						11	Y		
						11	Y		

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 place of service listing).

24 . A. DATES OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	**B. PLACE OF SERVICE**	C. EMG	D. PROCEDURE, SERVICE OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
02	15	13	02	15	13	**11**	Y		
02	15	13	02	15	13	**11**	Y		

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

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

24 . A. DATES OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	**C. EMG**	D. PROCEDURE, SERVICE OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
02	15	13	02	15	13	11	**Y**		
02	15	13	02	15	13	11	**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 (Field 24G) 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 provider and avoid delay or denial of payment.

24 . A. DATES OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	**D.** PROCEDURE, SERVICE OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
02	15	13	02	15	13	11	Y	**99214**	
02	15	13	02	15	13	11	Y	**71010**	**26**

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. This field allows for the entry of 4 characters and no punctuation should be used.

D. PROCEDURE, SERVICE OR SUPPLIES) (Explain Unusual Circumstances					E.	F.		G.	H.
CPT CODE	MODIFIERS				DIAGNOSIS POINTER	$ CHARGES		DAYS OR UNITS	EPSDT FAMILY PLANNING
99214					**AB**	79	00	1	
71010	26				**A**	150	00	3	

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. Dollar Amount should be right justified.

D. PROCEDURE, SERVICE OR SUPPLIES) (Explain Unusual Circumstances					E.	F.		G.	H.
CPT CODE	MODIFIERS				DIAGNOSIS POINTER	$ CHARGES		DAYS OR UNITS	EPSDT FAMILY PLANNING
99214					AB	**79**	**00**	1	
71010	26				A	**150**	**00**	3	

24G. 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. PROCEDURE, SERVICE OR SUPPLIES) (Explain Unusual Circumstances					E.	F.		G.	H.
CPT CODE	MODIFIERS				DIAGNOSIS POINTER	$ CHARGES		DAYS OR UNITS	EPSDT FAMILY PLANNING
99214					AB	79	00	**1**	
71010	26				A	150	00	**3**	

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

24I. ID Qualifier **Required if applicable**

Enter in the shaded area of 24I 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.

The NUCC defines the following qualifiers used in 5010A1:

0B State License Number
1G Provider UPIN Number
G2 Provider Commercial Number
LU Location Number
ZZ Provider Taxonomy

24J. (SHADED AREA) – Use for COB INFORMATION **Required if applicable**

Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a member's deductible has been met, enter zero (0) for the Deductible amount.

For members and service covered by a third party payer, enter only the amount ***paid.***

Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the member has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

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

Rendering Provider's NPI is required for all providers that are mandated to maintain 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 PLANNING	I. EPSDT FAMILY PLANNING	J. RENDERING PROVIDER ID #
AB	79 00	1			**COB INFORMATION**
A	150 00	3			**NPI Rendering Provider NPI ID #**

25. Federal Tax ID Number Required

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

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
123456789	☐	☒	

26. Patient Account Number Required if applicable

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. Mercy Care will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the claim and the provider's own accounting or tracking system.

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	**26**. PATIENT ACCOUNT NO. **PROVIDER UNIQUE CLAIM IDENTIFIER**
	☐	☒	

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)	**28.** TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
☐ YES ☐ NO	**$ 229**	**00**	$		$	

29. Amount Paid **Required if applicable**

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

27. ACCEPT ASSIGNMENT (For govt claims, see back)	28. TOTAL CHARGE		**29.** AMOUNT PAID		30. BALANCE DUE	
☐ YES ☐ NO	$ 229	00	**$ 0**	**00**	$	

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 if initialed by the provider representative. Enter the date on which the claim was signed.

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 03/04/13

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

Enter the name, address, city, state and ZIP code of the LOCATION WHERE THE SERVICES WERE RENDERED.

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 Scottsdale, AZ 85252	
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. Billing Provider Info & PH # (520) 5551234 Doc Holiday 123 OK Corral Dr Tombstone AZ 85999 602-111-1111
a. NPI **b.** AHCCCS ID