CMS-1500 (02-12) Health Insurance Claim Form

Physician and non-physician, professional services, laboratory, independent diagnostic testing facilities (IDTF), ambulance and other transportation, EPSDT service, ambulatory surgical center, family planning, behavioral health service, vision, therapists (speech, physical and occupational), health department, and durable medical equipment supplier must bill on the CMS-1500.

Table of WV Medicaid Required Fields, Comments, Etc.

Required Field:

Blank = Not Required
C = Conditionally Required
R = Required Field

Form Locator	Required Field	Field Name	Comments
1A	R	Insured's ID Number	Enter the 11 (eleven)-digit THP member ID.
2	R	Patient's Name	Enter name of the patient. Last Name, First Name and Middle Initial. Include any suffix (Jr., Sr.).
3	R	Patient's Birth date and Sex	Enter the valid date of birth. Format = MMDDCCYY or MMDDYY. Check the correct box for patient sex. Male (M) Female (F)
4		Insured's Name	No entry required.
5	R	Patient's Address	Enter the patient's full address. Street Address, City, State and 9-digit ZIP Code.
6		Patient's Relationship to the Insured	No entry required.
7		Insured's Address	No entry required.
8		Reserved for NUCC Use	No entry required.
9	C	Other Insured's Name	Enter the policyholder's name of Insurance other than Medicaid that covers this patient - If no other insurance, skip to Form locator 10.
9A	C	Other Insured's Policy or Group Number	Enter policy or group number of the insurance.
9B		Reserved for NUCC Use	No entry required.
9C		Reserved for NUCC Use	No entry required.

Form Locator	Required Field	Field Name	Comments
9D	C	Insurance Plan Name or Program Name	Enter the plan name of insurance other than Medicaid.
10		Is Patient's Condition related to:	If condition is related to box 10a, 10b, or 10c then a date is required in box 14.
10A	C	Employment?	Indicate yes or no with an "X" if the patient's condition is related to employment; if yes, then a date is required in box 14.
10B	C	Auto Accident?	Indicate yes or no with an "X" if the patient's condition is related to an auto accident. If yes, enter the 2-digit state abbreviation of the state where the auto accident occurred, and a date is required in box 14.
10C	C	Other Accident?	Indicate yes or no with an "X" if the patient's condition is related to an accident other than an auto accident. If yes, a date is required in box 14.
10D		Claim codes (Designated by NUCC)	
11		Insured's Group Number	No entry required.
12		Patient's Signature	No entry required.
13		Insured's Signature	No entry required.
14	C	Date of Current Illness, Injury and/or Pregnancy	Enter valid date of current accident (auto or other). Format = MMDDCCYY or MMDDYY **Required if box 10b auto accident &/or box 10c other accident is marked Yes. Enter valid date of current onset of illness if not related to "cause check" in 10a, b or c. Format = MMDDCCYY or MMDDYY.
15		Other Date	No entry required.
16		Dates Patient Unable to Work	No entry required.
17	C	Name of Referring Physician or Other Source	Enter Last Name and First Name of referring physician or other source.
17A	C	Referring Physician's Identification Number	NPI is required unless provider is not eligible per NPPES and uses Atypical Provider Identification (API). EI - Employer's identification number SY - SSN OB - State license number

Form Locator	Required Field	Field Name	Comments
			1G-UPIN number Leave blank if NPI is entered in 17b.
17B	C	Referring Physicians NPI	Enter the 10-digit NPI of the referring physician.
18		Hospitalization Dates	No entry required.
19	C	Reserved for Local Use:	No entry required.
20		Outside Lab	No entry required.
21	R	ICD Indicator	Enter 0 for ICD-10. Note: This is a 1-digit field.
21A-L	R	Diagnosis code	Enter diagnosis codes in priority order (primary, secondary, etc.). Diagnosis code 'A' is required.
22	C	Resubmission Code / Original Reference Number	Medicaid Resubmission Code: Valid values = 1, 7 or 8. 1= Initial Claim 7= Prior claim/Replacement 8= Cancellation of Prior Claim
23	C	Prior Authorization Number	Enter the prior authorization number, if applicable for the claim - The claim must be split if more than one prior authorization number applies.
24	R	Service Lines	**At least one service line is required. Maximum of 6 lines per claim.
24A	R or C	NDC number-Shaded area (required when billing CPT/HCPCS codes for a drug)	Shaded area: **Drug codes require NDC**. Enter the NDC qualifier of N4, followed by an 11-digit NDC number. • Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC number. **The NDC number submitted to THP must be the actual NDC number on the package or container from which the medication was administered.**
	R	Dates of Service-Unshaded area	Unshaded area: Enter the From and To date(s) the service was provided, using the following format **MMDDYY.** "From Date" must be less than or equal to the "To Date".
24B	R	Place of Service (Unshaded area)	Enter the appropriate 2-digit code for place of service. Refer to CMS for the most current POS table:

Form Locator	Required Field	Field Name	Comments
			cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
24C	C	EMG – Unshaded area	If emergency, then enter 'Y' for Yes.
24D	C	NDC unit measurement-Shaded area	Shaded area: Enter the NDC unit of measurement and numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal point and three numbers may follow the decimal. The unit of measurement codes are: • F2 -International Unit • GR-Gram • ML-Milliliter UN- Unit Refer to dhhr.wv.gov/bms for additional NDC billing instructions/FAQ's
	R	Procedure Code- Unshaded area	Unshaded area: Enter the 5-digit CPT or HCPCS procedure code that describes the procedure performed. If service provided requires modifier(s), enter up to four modifiers in the column(s) provided following the CPT or HCPCS code.
24E	R	Diagnosis Pointer –unshaded area	Enter the letters from block 21 that identify the diagnosis codes. Applicable to the procedure billed on the line. The reference letters A - H are required. Note: I – L are not allowed at this time.
24F	R	Charges	Enter the total charge for the procedure performed. ***Note* If no decimal point is present, the amount left of the divider on claim form will be captured as whole dollars and the amount to the right of divider as cents.*
24G	R	Unit(s)	Enter the quantity or number of units of the service provided.
24H	C	EPSDT/Family Planning (For providers participating in EPSDT and Family Planning programs only)	WV Medicaid valid values include: Y = EPSDT N = Non-EPSDT

Form Locator	Required Field	Field Name	Comments
24I	C	ID Qualifier – Shaded Area	Enter PXC when entering the taxonomy code for the servicing provider in block 24j.
24J	C	Rendering provider's Legacy Medicaid ID – Shaded area Rendering provider's NPI - Unshaded area	NPI is required unless provider is not eligible per NPPES and uses Atypical Provider Identification (API). Atypical providers should contact THP to obtain atypical provider number Unshaded area: Enter the rendering provider's NPI number on each line billed. Entry is *required* if the provider is a physician, APRN, therapist, etc.; a person and the payment/remit is going to a group or "pay-to" location documented in block 33.
25	R	Fed Tax ID	Indicate whether the Federal Tax ID# is SSN or EIN. Enter Federal Tax ID#. Must be 9 numeric characters.
26	R	Patient's Account Number	Enter patient's account number or name. Alphanumeric characters may be used (maximum of 20). The account number or name will be printed on the WV Medicaid remittance advice.
27		Accepts Assignment	No entry required.
28	R	Total Charge	Enter total charges. Note: For multiple page claims, enter total charges on the last page only. Multiple page claims must specify page (1 of 2, 2 of 3, etc.) on the top of the claim.
29	C	Amount Paid	Attach Medicare and/or TPL EOBs to claim form.
30		Balance Due	No entry required.
31	R	Signature and Date	Signature of person authorized to certify this claim. Enter the claim submission date.
32	C	Service Facility Location Information	Enter facility Name, address, city, state and 9-digit ZIP Code. **Required if 32A contains service facility location NPI.
32A & B	C	Servicing Facility NPI Servicing Facility Taxonomy	Enter service facility NPI number format.

Form Locator	Required Field	Field Name	Comments
33	R	Billing Provider Info and Phone number	Enter required billing provider information as followed: • Phone • Name • Street Address • City, State & 9-digit ZIP Code
33A	R	NPI number of Physician, Group, or Supplier	Enter the NPI of the billing provider, group or pay-to. If there is a servicing/rendering in 24j then enter the pay to or group NPI number in 33a.
33B	C	Taxonomy code of Physician, Group, Supplier, or Pay To	Enter PXC (qualifier) if you are entering in a taxonomy code for the provider in 33A. (No spaces between qualifier and value.)