08/05 CMS-1500

Claim form billing instructions for

Mental Health Licensed Residential Providers

Department of Human Services

July 2009

DHS
Oregon Department
of Human Services

Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the 08/05 CMS-1500 billing form correctly the first time. If applicable, this presentation is to be used in conjunction with your specific program guidelines.

We hope you find this tutorial helpful.

~ DHS ~

MMIS

- The federal government requires DHS to process Medicaid claims through the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted on the claim and other system related data (*e.g.*, eligibility).

Claim processing times

- 80% of the department's claim volume is electronic.
- Electronic claims process in real-time and usually adjudicate the week in which they are submitted.
- Paper claims may take up to three weeks for processing.
- DMAP pays providers on a weekly Friday cycle.
- Electronic fund transfers are processed on Wednesdays in the week following the Friday claims cycle.
- Less than two percent of claims suspend. Once they suspend, DMAP works them within 14 days.

Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- Effective August 1, 2009, DHS only accepts “red form” paper claims (not black and white copies).
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

Prior to submitting a claim

- Verify Plan of Care to assure you are billing according to the plan.
- Check the provider number to verify the claim will be submitted for the correct provider.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your handwriting is legible and clearly indicates zero's (0) versus O's, five's (5) versus S's, one's (1) versus L's, and eight's (8) versus B's.
- If possible, submit no more than one line of service per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

AFH changes

- *Prior to December 2008:*
  - Mental Health Licensed Residential providers were not required to bill for services provided to Oregon Health Plan (OHP) clients.
  - Payment was sent to providers based on the Plans of Care for clients living in the home.
- *Effective December 2008:*
  - Mental Health Licensed Residential providers are responsible for billing services for each client living in the home.
  - Once the claims have been submitted and show a status of PAID, payment is issued.
  - A Remittance Advice (RA) is sent with the check explaining each transaction that took place during the billing period.

Form suppliers

- The CMS-1500 form is not supplied by DHS.
- Forms are available by contacting one of the following:
  - Local business forms suppliers
  - Standard Register Company, Forms Division (800-755-6405)

Introducing the CMS-1500 claim form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐☐☐ PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) 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. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

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 ____________

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID 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. BALANCE DUE $

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.

08-05 version

Not sure if you are using the correct form?

The bottom right corner should say 08-05.

Top section

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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)

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

8. PATIENT STATUS Single Married Other

Employed Full-Time Student Part-Time Student

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 ______

Red = Required

Box 1a

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

Client ID Number

- Enter the resident’s eight-character prime identification number.
- Enter the number exactly as it appears on the Plan of Care.

Box 2

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

Resident, Your

Patient's Name

- Enter the resident's name exactly as it appears on the Plan of Care.
- Use the resident's last name first.
- Do not use nicknames.

Box 9

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

NC

Third Party Liability

- Third party liability represents other coverage that must be billed before DMAP (client's private insurance).
- **Always and only put NC in this field.**

Middle section

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____
2.
3. ____ . ____
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Red = Required

Box 17a

17a.		##########

Referring Provider Number

- Enter the six or nine-digit referring provider number.
- This will be the county mental health program provider number.

Box 21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V629 .
2. .
3. .
4. .

Diagnosis Code

- Enter the resident's DSM-IV (diagnostic and statistical mental disorders) or ICD-9 (international classification of diseases) diagnosis.
- Diagnosis codes are 3, 4 or 5 digits billed at it's highest level of specificity.
- Do not use the decimal point.

Bottom section

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. #

NPI
NPI
NPI
NPI
NPI
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. BALANCE DUE $

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.

Red = Required

Yellow = Optional

Box 24A

24. A. DATE(S) OF SERVICE From			To		
MM	DD	YY	MM	DD	YY
04	01	09	04	30	09

Date of Service

- This box must list numeric dates of service.

Box 24B

B. PLACE OF SERVICE
12

Place of Service

- Enter the two-digit place of service code of where the service was provided.
- Place of service codes:

  Adult Foster Homes must use **12**

  Residential Treatment must use **56**

Box 24D

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			
S5141	HK			

Procedure Code

- Enter the five-digit/character procedure code.
- Enter the modifier that reflects the service being provided.
- Refer to the next slide for a list of the required procedure code and modifier for the service being provided.

Procedure codes and modifiers

- Adult Foster Home
  - Procedure ***S5141***
  - Modifier ***HK***
- Residential Treatment Home
  - Procedure ***S5140***
  - Modifier ***HK***
- Residential Treatment Facility
  - Procedure ***T2048***
  - Modifier ***HK***
- Secure Residential Treatment Facility
  - Procedure ***T2048***
  - Modifiers ***HK*** and ***TG***

Box 24E

E. DIAGNOSIS POINTER

E. DIAGNOSIS POINTER
1

Diagnosis Pointer

- Enter the one-digit diagnosis code reference number (pointer) as shown in box 21 to relate the date of service and the procedure performed to the primary diagnosis.
- Do not enter the actual DSM-IV or ICD-9-CM code here.

Box 24F

F.

$ CHARGES

2730 | 60

Total Charges

- Enter the total usual and customary charge.
- Do not list credits.
- Do not use dashes.

Box 24G

G.
DAYS
OR
UNITS

1

Service Days or Units

- Enter the number of units

  1 unit = 1 month for Adult Foster Homes

  1 unit = 1 day for Residential Treatment

Box 24J

J.
RENDERING
PROVIDER ID. #

#########

Rendering Provider ID

- This box identifies who rendered the service.
- Shaded - Enter your six (6)-or nine (9)-digit DHS issued provider number

Box 28

28. TOTAL CHARGE

$ 2730 | 60

Total Charge

- Enter the total charge amount for all services listed in column 24F.
- Each claim form is a separate document, and is to be totaled as such.

Box 29 - Optional

29. AMOUNT PAID

$

Amount Paid

- Enter the total amount paid by any prior resource(s).
- This includes the client responsibility.
- Do not include how much DHS previously paid.

Box 30

30. BALANCE DUE

$ 2730 | 60

Balance Due

- Enter the balance due.
- Box 28 minus box 29 must equal box 30.

Box 33

33. BILLING PROVIDER INFO & PH # ( )
Billing Provider
PO Box ###
Anytown, OR 97###

a. NPI | b. #########

Billing Provider Information

- Box 33 - (Billing provider info & phone number) Enter the name and address of the provider that is requesting to be paid for the services rendered.
- Box 33b - (Other ID) Enter your six (6)-or nine (9)-digit DHS issued provider number. This is who gets paid.

COMPLETED EXAMPLE

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): XX###X#X

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

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) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code)

8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO; b. AUTO ACCIDENT? YES NO PLACE (State); c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

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: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. ###### — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V62 9
2.
3.
4.

22. MEDICAID 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: 04	01	09	04	30	09	12		S5141	HK	1	2730 60	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 $ 2730 60

29. AMOUNT PAID $

30. BALANCE DUE $ 2730 60

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 # ( )

Billing Provider
PO Box ###
Anytown, OR 97###

a. NPI b. #########

NUCC Instruction Manual available at: www.nucc.org — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Resources

Where to mail your claim

- Mail your 08/05 CMS 1500 claim form to:

  DMAP
  PO Box 14955
  Salem, OR 97309-4957

Who to call if you need help

- Contact DMAP Provider Services if you need assistance or if you have questions concerning your CMS-1500 claim form.

- They can be reached at:

  DMAP Provider Services

  800-336-6016

  DMAP.providerservices@state.or.us

  Team.Provider-ACCESS@state.or.us

Thank you!