
CMS-1500 Billing Instructions

Line-by-line paper billing instructions
for Oregon Medicaid providers

Division of Medical Assistance Programs

Oregon
Health
Authority

Overview

- This presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the CMS-1500 billing form correctly the first time.
- If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.
- We hope you find this tutorial helpful.

Claims processing

- Paper claims are scanned into the claims processing system using Optical Character Recognition (OCR).
 - For OCR, you must use commercial “red form” claim forms and make sure certain fields are left-aligned.
- Electronic claims (Web and electronic data interchange) do not require specific claim forms or field alignment. Make sure you bill electronically whenever possible.
- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).

Before you bill

- Verify client eligibility on the date of service.
 - AMH Licensed Residential Providers must verify Plan of Care to make sure to bill according to the plan.
- Make sure you bill all prior resources first. Medicaid (DMAP) is the payer of last resort.
- Bill electronically if possible. You only need to bill on paper if you need to submit attachments with your claim, the claim is over a year old, and other certain instances.
- If you must bill on paper, use commercially available “red form” versions of the current CMS-1500.

Paper billing tips

- When submitting handwritten claim forms:
 - Use blue or black ink; never use red ink.
 - Make sure your handwriting is legible. Zeroes should look different from the letter “O,” the number one (“1”) different from the letter “l,” etc.
 - Don’t use liquid paper/whiteout to make corrections.
- If possible, submit no more than six lines of services per claim form.
 - If you need to bill more than six lines on a single claim, bill electronically. Then you don’t need to complete multiple paper claim forms.
- Check your printer alignment.

Form suppliers

- DMAP does not supply the CMS-1500 form.
- You can purchase forms by contacting one of the following:
 - Local business forms suppliers
 - Oregon Medical Association (503-226-1555)
 - U.S. Government Printing Office (202-512-1800)
- If you don't want to purchase claim forms, you can use the Provider Web Portal for free!

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BK/LLNG <input type="checkbox"/> OTHER <input type="checkbox"/>		18. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		8. PATIENT STATUS	
CITY STATE		CITY STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH	
b. AUTO ACCIDENT?		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
14. DATE OF CURRENT ILLNESS		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE		25. FEDERAL TAX I.D. NUMBER	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?	
28. TOTAL CHARGE		29. AMOUNT PAID	
30. BALANCE DUE		31. SIGNATURE OF PHYSICIAN OR SUPPLIER	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

08-05 version

- Not sure if you are using the correct form?

The bottom right corner should say 08-05. 

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Top section

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)						a. 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 _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)	
CITY _____		STATE _____	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY _____ STATE _____	
ZIP CODE _____		TELEPHONE (Include Area Code) _____	Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>			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) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH _____ SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? _____ PLACE (State) _____			b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? _____			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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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 _____	
SIGNED _____						DATE _____	

Red = Required

Yellow = Optional

Box 1a - Required

1a. INSURED'S I.D. NUMBER

(For Program in Item 1)

X X # # # X # X

- Recipient ID Number
 - Enter the client's eight-character Oregon Medicaid identification number.
 - Enter the number exactly as it appears on the Medical Care Identification (or the client's Plan of Care).

Box 2 - Required

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

Patient, Your

- Patient's Name
 - Enter the client's name exactly as it is printed on the Medical Care Identification (or the client's Plan of Care).
 - Use the client's last name first.
 - Do not use nicknames.

Box 9 - Optional

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

NC

- Third Party Resource
 - If the client has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
 - A code must be listed when the other insurance did not make a payment.
 - A code is always required when the client has more than one other insurance carrier.
 - AMH Adult Residential Providers – Only enter “NC” in this field.
 - Other providers – See next slide for TPR codes.

Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility
MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAFF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient
SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder
SR	Primary paid – Secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (If above codes do not apply, include detailed explanation of why no TPR payment was made)

Box 10 - Optional

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

YES NO

b. AUTO ACCIDENT? PLACE (State)

YES NO

c. OTHER ACCIDENT?

YES NO

- Patient's Condition
 - Check the appropriate box only when an injury is involved.
 - Do not check any boxes if there is no injury to report.

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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
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

Red = Required

Yellow = Optional

Box 17a - Optional

17a.

#####

- Referring Provider Number
 - Enter the six (6)-or nine (9)-digit DMAP provider number of the referring provider.
- This may be required if the client has a Primary Care Manager (PCM) or the service requires a referral (e.g., Physical Therapy, Occupational Therapy or Speech Therapy).
- This field is required for AMH Adult Residential Providers.

Box 17b - Optional

17b.	NPI	#####
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- National Provider Identifier (NPI) for referring provider
 - If you entered a DMAP provider in Box 17a (Primary Care Manager, or other referral), enter the 10-digit NPI registered under the DMAP provider ID used in Box 17a.
 - If you do not know what NPI to use, contact DMAP Provider Enrollment (800-422-5047).

Box 21 - Required

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			
1.	786 59	3.	250 61
2.	414 01	4.	465 9

- Diagnosis Code
 - Enter the ICD-9-CM code(s) for the client’s diagnosis/condition.
 - The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
 - You may enter up to four codes and they must be carried out to the highest degree of specificity.
 - Do not enter a decimal point.
 - Note: Diagnosis codes are not required for transportation providers or AMH Adult Residential Providers.

Box 23 - Optional

23. PRIOR AUTHORIZATION NUMBER

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- Prior Authorization Number
 - If the service you provided requires prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
 - Only use one prior authorization number per claim form.
 - Do not bill prior authorized and non-authorized services on the same claim form.

Supplemental qualifiers

Use when reporting the following services:

Qualifier	Description
7	Anesthesia
ZZ	Narrative description of unspecified codes
VP	Vendor Product Number
OZ	Health Care Uniform Code
CTR	Contract rate
N4	National Drug Code. Also use the following units of measure: <ul style="list-style-type: none">• F2 - International unit• GR - Gram• ML - Milliliter• UN - Unit

Supplemental information examples

National Drug Code

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER						
N412345678901 UN1234.567															123456789
MM	DD	YY	MM	DD	YY	1		J#####	UD [for 340B drugs]	1	### ##	20			NPI 1234567890

Anesthesia Services, in 15-minute units

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER						
7Begin 1245 End 1415 Time 90 Minutes															123456
06	01	07	06	01	07	1		00770	P2	1	### ##	6		NPI 1234567890	

Unspecified Code

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER						
ZZ Kaye Walker															123456
06	01	07	06	01	07	4		E1399		1	### ##	1		NPI 1234567890	

Vendor Product Number

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER						
VPA122BIC5D6E7G															123456
06	01	07	06	01	07	1		A6410		1	## ##			NPI 1234567890	

Box 24A - Required

24. A. DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
12	01	08			
12	03	08			
12	05	08	12	06	08

- Date of Service
 - This box must list numeric dates.
 - If billing for one day, complete only the “from” column.
 - Only use From and To dates for a service given on consecutive days and provided no more than once a day.

Box 24D - Required

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
CPT/HCPCS	MODIFIER
99213	21
99213	21
99213	21

- Procedure Code

- Enter the five-digit/ character CPT or HCPCS code(s) for the specific service provided.
- Optional - Enter up to four two-digit national modifiers that relate to this service.
- For procedure codes that indicate “unlisted,” you must attach an operative/medical report.
- AMH Adult Residential Providers should only bill using the codes on the next slide.

Procedure codes and modifiers for AMH adult residential providers

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 - Required

E. DIAGNOSIS POINTER
1
1
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 ICD-9-CM code here.

Box 24F - Required

F.
\$ CHARGES
93 00
93 00
186 00

- Total Charges
 - Enter the total usual and customary charge for each line.
 - Do not list credits.
 - Do not use dashes.
 - DMAP will not calculate your charge if billing for more than 1 item (unit).

Box 26 - Optional

26. PATIENT'S ACCOUNT NO.

X123400

- Patient Account Number
 - Enter your patient account number here.
 - This box allows up to twelve characters.
 - This number will appear on your Remittance Advice (RA).

Box 28 - Required

28. TOTAL CHARGE	
\$	372 00

- 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).
 - For AMH Adult Residential Providers, this includes client responsibility.
 - Do not include write-offs.
 - Do not include how much DMAP previously paid.
 - Do not include copayments.

Box 30 - Required

30. BALANCE DUE	
\$	372 00

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

Box 33 - Required

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

- Billing Provider Information – Enter information for the provider number DMAP will direct payment to:
 - Box 33 - Enter the name and address of the billing provider.
 - 33a - Enter the NPI registered with the billing provider’s DMAP ID number (listed in Box 33b).
 - 33b - Enter the billing provider’s DMAP ID.
- Note: Non-medical services (e.g., taxis) do not require NPI.

Completed CMS-1500 claim form

EXAMPLES

Medical Clinic

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA												<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) XXXXXX											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Name		3. PATIENT'S BIRTH DATE MM DD YY 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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		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) NC		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # if yes, return to and complete item 9 a-d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI #####		17b. NPI #####		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
1. 786.59		2. 250.61		3. 414.01		4. 465.9							
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. ESSET Family Ref	I. ID. QUAL	J. RENDERING PROVIDER ID. #		
1. 12 01 08		11	99213	21		1	93.00	1	1	#####			
2. 12 03 08		11	99213	21		1	93.00	1	1	#####			
3. 12 05 08 12 06 08		11	99213	21		1	186.00	2	1	#####			
4.													
5.													
6.													
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (Per gov. docs, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 372.00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 372.00	
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.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#		Billing Provider PO Box ### Anytown, OR 97### a. ##### b. #####							
SIGNED _____ DATE _____		a. NPI		b.									

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Division of Medical Assistance Programs

Oregon Health Authority

AMH Adult Residential

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small>										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										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										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) NC										11. INSURED'S POLICY GROUP OR FECA NUMBER									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. Days or Units H. EPST Form I. ID. QUAL J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 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.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # () Billing Provider PO Box ### Anytown, OR 97###										34. SIGNATURE AND DATE									

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	DMAP PO Box 14955 Salem, OR 97309-4955
Help with paper billing	DMAP Provider Services 1-800-336-6016 E-mail: dmap.providerservices@state.or.us
Provider Web Portal – Free paperless Web billing (for individual claims)	https://www.or-medicaid.gov
Electronic business practices (billing, payment and more)	www.oregon.gov/DHS/healthplan/ebp.shtml
Provider training	www.oregon.gov/DHS/healthplan/tools_pro v/training.shtml

THANK YOU!