
A Guide for Completing the

# CMS-1500 Form

The Form CMS-1500 is the standard claim form used by Physicians and Ancillary Providers to bill professional services and Durable Medical Equipment. Baylor Scott & White Health Plan offers this guide to help you complete the CMS-1500 form for your patients with Baylor Scott & White Health Plan coverage.

Thank you for helping us to process your claims efficiently and accurately.

**MAIL CLAIMS TO:**

**Baylor Scott & White Health Plan**
**P.O. Box 21800**
**Eagan, MN 55121-0800**

1500

# HEALTH INSURANCE CLAIM FORM

# SAMPLE

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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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) — R

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other — R

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

CITY — STATE

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

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) — C

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER — R

a. OTHER INSURED'S POLICY OR GROUP NUMBER — C

a. EMPLOYMENT? (Current or Previous) YES — R — NO

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

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

b. AUTO ACCIDENT? YES — R — NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME — C

c. OTHER ACCIDENT? YES — R — NO

c. INSURANCE PLAN NAME OR PROGRAM NAME — R

d. INSURANCE PLAN NAME OR PROGRAM NAME — C

10d. RESERVED FOR LOCAL USE — C

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES — R — 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. — R

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. — R

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD — C — 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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — NR

17a. — NR

17b. NPI — C

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

19. RESERVED FOR LOCAL USE — C

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) — R

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER — C

| 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 | | R | R | R | | R | R | R | | NR | NR / C |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN — R

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ — R

29. AMOUNT PAID $ — C

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.) — R

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — SW

a. — C b. — NR

33. BILLING PROVIDER INFO & PH # ( ) — R

a. — R b. — NR

NUCC Instruction Manual available at: www.nucc.org

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**KEY**

- R — TDI Requirement
- C — TDI Conditional Element
- N — Not Required/Not Used
- S — Baylor Scott & White Health Plan Requested Element

**1. Type of Health Insurance**

**1a. Insured ID Number:** Enter the ID number found on the insured's Baylor Scott & White Health Plan card.

**2. Patient's Name:** Enter patient's Last name, First name, middle initial . R

**3. Patient's Birth Date/Sex:** Enter patient's date of birth using an eight-digit format (MM/DD/CCYY), Enter "X" in appropriate box to indicate patient's sex. R

**4. Insured's Name:** Enter insured's Last name, First name, Middle initial. R

**5. Patient's Address/Telephone Number:** Enter patient's permanent mailing address and telephone number, Street, City, State, Zip Code. R

**6. Patient's relationship to Insured:** Place an "X" in the appropriate box for patient's relationship to the insured. R

**7. Insured's Address:** Enter insured's Street, City, State, Zip Code (complete if different than patient's address). R

**8. Patient Status:** Place "X" in the appropriate box for patient's marital, student and employment status.

**9. Other Insured's Name:** Enter other insured's Last name, First name, Middle initial, if applicable. When the patient has other insurance coverage complete 9 through 9d. This C

**9a. Other insured's policy or group number:** Enter group number and name, Medigap Policy number, Employee ID number of the other insured. C

**9b. Other insured's date of birth and sex:** Enter other insured's date of birth using (MM/DD/CCYY) format and mark an "X" to indicate insured's sex. C

**9c. Employer's name or school name:** Enter other insured's employer. C

**9d. Insurance plan name or program name:** Enter other insured's group name. C

***10 a-d. Is patient's condition related to***

**10a. Employment:** For employment related indicator, place an "X" in the appropriate box R

**10b. Auto Accident:** For auto accident related indicator, place an "X" in the appropriate box. If yes, enter the state in which the accident occurred. Use two-character abbreviation, R

**10c. Other Accident:** For other accident related indicator, place an "X" in the appropriate box. R

**10d. Reserved for local use:** If claim is a duplicate claim, a "D" is required. If claim is a corrected claim, a "C" is required. C

***(11 thru 11d, refer to Baylor Scott & White Health Plan subscriber coverage)*** R

**11. Insured's policy group or FECA number:** Enter the group number from the subscriber's insurance card.

**11a. Insured's date of birth and sex:** Enter insured's date of birth using (MM/DD/CCYY) format and mark an "X" to indicate insured's sex.

**11b. Employer's name or school name:** Enter insured's employer or school.

**11c. Insurance plan name or program name:** Enter insured's insurance name.

**11d. Is there another health insurance benefit plan:** Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other

**12. Patient or authorized person's signature:** Signature required but may indicate "Signature on File". R

**13. Insured's or authorized person's signature:** Signature required but may indicate "Signature on File". R

**14. Date of current illness, injury, pregnancy:** Enter date using (MM/DD/CCYY) format. C

15. If patient has had same or similar illness give first date: Enter date using (MM/DD/CCYY) format.

16. Date patient unable to work: From date, To Date. Enter date using (MM/DD/CCYY) format.

17a. Other ID#: Not required.

17b. NPI#: Enter the 10-digit NPI number of the referring, ordering, or supervising provider.

20. Outside lab/charges: If lab was performed outside the physician's office, place an "X" in "yes" box and enter total charges.

21. Diagnosis or nature of illness or injury: Enter the ICD-9-CM codes. The primary diagnosis should be first, followed by other diagnoses. Enter up to 4 ICD-9-CM codes. R

22. Medicaid Submission Code: Enter Medicaid Submission Code, if applicable.

23. Prior Authorization Number: Required if a Preauthorization or Verification is done. C

24. Shaded Area– Supplemental Information: The shaded area of field 24a-24h was created to accommodate supplemental information (i.e. Anesthesia.) R

24a. Date(s) of service: From, To. Enter dates of service using (MM/DD/CCYY) format. R

24b. Place of service: Enter the appropriate 2 digit Place of Service code (must be valid industry standard codes). R

24c. EMG: Emergency indicator—Y for "Yes" or N for "No." R

24d. Procedures, Services, or Supplies: Enter the CPT or HCPCS code for the procedures, service or suppiers and enter a modifier, if applicable. (Must be valid industry codes. ) R

24e. Diagnosis Code: Enter one OCD-9-CM diagnosis code for each procedure performed, Enter onele one code per line of service. R

24f. Charges: Enter charge for each line of service. (This should be original charge not the balance due or patient liability. Do not include discounts.) R

24g. Days or Units: Enter number of days or units. R

24h. EPSTD Family Plan: For Early & Periodic Screening, Diagnosis, or Treatment or family planning services.

24i. ID Qualifier: Not required.

24j. Rendering Provider ID.#: Shaded Field—Not Required. Non-Shaded Field– Enter performing provider 10-digit NPI number. C

25. Federal Tax I.D. Number: Enter the provider of services' Federal Tax ID number. Place an "X" in the appropriate box or SSN or EIN. R

26. Patient Account Number: Enter account number assigned to patient, if applicable.

27. Accept Assignment: Enter "Yes" if the provider should be paid or enter "No" if the patient should be paid. C

28. Total Charge: Enter total charges. This should total all charges in 24hr. R

29. Amount Paid: Enter any amount paid by the patient. C

30. Balance Due: Enter the difference, if any, between the total charge and amount paid.

31. Signature of Physician or Supplier: The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated using an eight-digit date format (MM/DD/CCYY). R

32. Service Facility Location: Enter location where services were rendered. According to Texas state law, this field is required if the services were performed somewhere other than the patient's home.

32a. NPI#: Enter the 10-digit NPI number of the service facility location. C

32b. Provider ID#: Not required.

33. Billing Provider Info & Phone: Enter provider's or supplier's information that is requesting to be paid for services rendered. R

33a. NPI#: Enter the 10-digit NPI number of the service facility location. R

33b. Provider ID#: Not required.