BlueCross BlueShield Kansas

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This sample form is for Blue Cross and Blue Shield of Kansas education purposes only and should not be used to submit actual claims. DO NOT DUPLICATE.

LEGEND:
- Not Required
- Required
- Helpful
- Required if Applicable
- Your Choice

THIS FORM IS NOT TO EXACT PRINT SPECIFICATIONS

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)
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. RESERVED FOR NUCC USE	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)	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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. CLAIM NUMBER
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CONDITION CODES AND OTHER	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) QUAL.	15. OTHER DATE QUAL. 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	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) V A. B. C. D. E. F. G. H. I. J. K. L.		22. 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. Rsvd for NUCC Use
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.		

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0999 FORM CMS-1500 (02/12)

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. RESERVED FOR NUCC USE	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)	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. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. CLAIM NUMBER
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CONDITION CODES AND OTHER	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 _____

Box 1:

- Required field
- Always check "OTHER" when submitting a claim for any BCBSKS product
- Common errors:
    - Box is not checked or is marked incorrectly

Boxes 2 & 5:

- Required fields
- Enter patient's full name and complete address
    - The word "same" can be used only if the patient and policyholder are the same person
- Common errors:
    - Leaving any field blank
    - Using the patient's nickname or initials
    - Using the policyholder's name instead of the patient's name
    - Not listing the last name first

Boxes 3 & 6:

- Required fields
- Date of birth = 8 digits MM/DD/YYYY
- Common errors:
    - Date of birth is missing or invalid
    - Patient's relationship to the insured is not marked or is marked incorrectly

Box 8:

- Not used at this time

Box 1a, 4 & 7:

- Required fields
- Enter member ID number and policyholder's name exactly as they appear on the insurance ID card
- Always maintain a copy of the card in the patient's file
- Common errors:
    - Not including the alpha-prefix
    - Using the policyholder's nickname or initials
    - Not listing the last name first
    - Not including punctuation showing on ID card (e.g., Joe Roberts-Smith)
    - Entering an SSN instead of the ID number
    - Leaving any of the fields blank

Boxes 9-9d:

- Boxes 9, 9a & 9d are required, if applicable
- Boxes 9b & 9c are not required
- Must be completed when there are multiple insurance policies
    - Regardless of whether they are both BCBS policies or various payers
- Common errors:
    - Leaving these fields blank if other insurance exists

Boxes 10a-10d:

- Boxes 10a-10c are required
- Box 10d is not required
- Check boxes a, b & c "yes" or "no"
    - If "yes" is indicated in any of the boxes, Other Party Liability (OPL) rules may apply
- Common errors:
    - Leaving these fields blank
    - Indicating "yes" to any box but not indicating the date of accident in box 15
    - Indicating "yes" to any box but not using an accident diagnosis code as the primary diagnosis code in box 21a

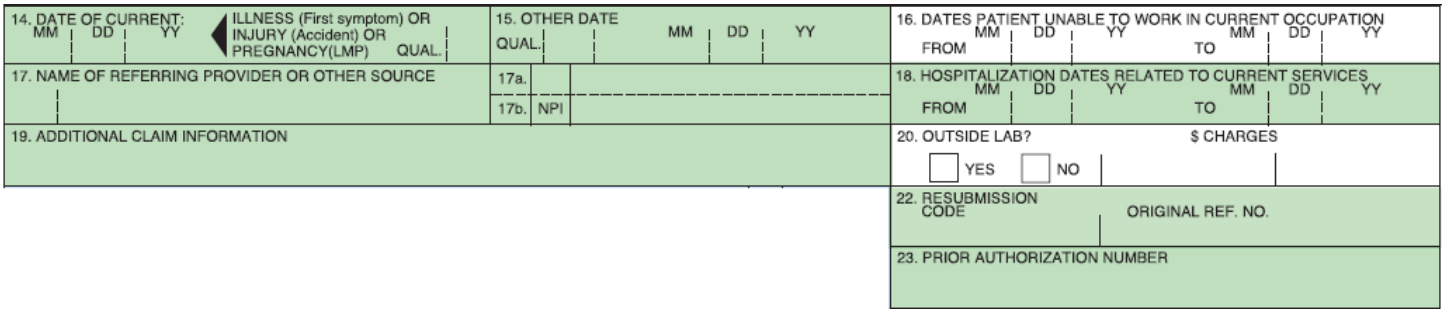
Boxes 11-11d:

- Boxes 11 & 11a are required
- Boxes 11b-11d are helpful but not required
- Enter the policyholder's group or FECA number in box 11
- Enter the policyholder's date of birth and select the policyholder's gender in box 11a
    - Regardless of whether the policyholder and the patient are the same person
- Common errors:
    - Entering "same" in box 11
    - Leaving the date of birth and/or gender blank

Boxes 12 & 13:

- Required fields
- Enter the legal signature, "Signature on File", or "SOF"
    - If legal signature, enter date signed in 6-digit MM/DD/YY or 8-digit MM/DD/YYYY format
    - If no signature on file, enter "No Signature on File"

Physician or Supplier Information



Box 14:

- Required, if applicable
- Enter date in 6-digit MM/DD/YY or 8-digit MM/DD/YYYY format to indicate first date of present illness, injury, or pregnancy
    - For pregnancy, use date of last menstrual period (LMP) as first date
- Enter applicable qualifier to the right of the vertical dotted line
    - Qualifier 431: onset of current symptoms or illness
    - Qualifier 484: last menstrual period
- Common errors:
    - Entering the date of the accident in box 14 instead of box 15
    - Not entering the qualifier to the right of the vertical dotted line

Box 15:

- Required, if applicable
- Enter another date related to the patient's condition or treatment
    - Enter date in 6-digit MM/DD/YY or 8-digit MM/DD/YYYY format
    - If box 10a, 10b or 10c is marked "yes", qualifier 439 must be used
- Enter applicable qualifier to identify which date is being reported
    - Qualifier 090: report state (assumed care date)
    - Qualifier 091: report end (relinquished care date)
    - Qualifier 304: latest visit or consultation
    - Qualifier 439: accident
    - Qualifier 444: first visit or consultation
    - Qualifier 453: acute manifestation of a chronic condition
    - Qualifier 454: initial treatment
    - Qualifier 455: last x-ray
    - Qualifier 471: prescription
- Common errors:
    - Not entering date of accident in box 15
    - Leaving box 15 blank when an exact date is not known

Box 16:

- Not required

Box 18:

- Required, if applicable
- Enter 6-digit MM/DD/YY or 8-digit MM/DD/YYYY hospital admission date followed by hospital discharge date if it has occurred
    - If not discharged, leave discharge field blank
    - This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization

Boxes 17-17b:

- Required, if applicable
- Referring, ordering, or supervising provider qualifier, name and NPI must be reported for any claim with a radiology procedure (7xxxx), laboratory service (8xxxx), diagnostic/vaccination/immunization/administration (9xxxx), or HCPCS CPT code (excluding ambulance)
- Box 17: Enter provider qualifier and name
    - Qualifier DN: referring provider
    - Qualifier DK: ordering provider
    - Qualifier DQ: supervising provider
- Box 17b: Enter provider NPI
- Common errors:
    - Not entering the appropriate qualifier in box 17
    - Entering a number other than the provider NPI in box 17b

Box 19:

- Required, if applicable
- Enter any additional information necessary for the claim submitted

Box 20:

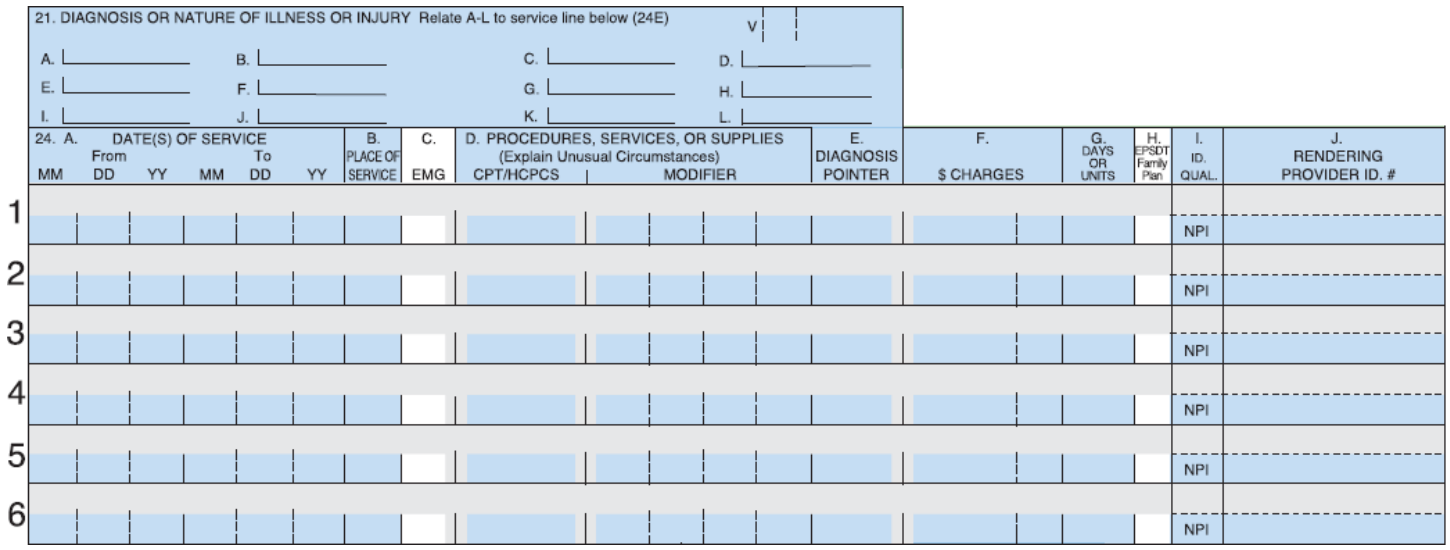
- Not required

Box 22:

- Required, if applicable
- Enter resubmission code and original reference number to request replacement of or to void/cancel a prior claim
    - Resubmission code 7: replacement of a prior claim
    - Resubmission code 8: void/cancel a prior claim
    - Original reference number: claim number from original claim to replace or void
- Common errors:
    - Entering the wrong resubmission code or claim number in box 22
    - Leaving this field blank and only entering “corrected claim” or similar in box 19

Box 23:

- Required, if applicable
- Enter the Prior Authorization (PA) number for any service(s) pre-authorized
- Common errors:
    - Not completing this field when a PA has been obtained



Box 21:

- Required field
- Enter the primary diagnosis code in blank A.
- Enter any subsequent diagnosis codes in blanks B. – L., as applicable
    - Every listed diagnosis code must be attributed to at least one service in box 24E
- Common errors:
    - Not entering diagnosis codes at the highest level of specificity
    - Listing an accident diagnosis code as primary but not completing boxes 10 & 15
    - Listing a diagnosis code but not attributing it to a service in box 24E

Box 21V:

- Required field
- Enter '0' (zero) to indicate ICD-10 was used
- Common errors:
    - Leaving this field blank

Box 24A:

- Required field
- Enter dates of service on each line item even if they are the same
    - When dates of service are consecutive with the same procedure code, enter total days or units in box 24G
    - Intermittent dates of service must be entered on separate lines

Box 24B:

- Required field
- Enter the appropriate place of service for each line item
    - 02: telehealth
    - 10: telehealth provided in patient's home
    - 11: office
    - 12: patient's home
    - 21: inpatient hospital
    - 22: outpatient hospital
    - 23: emergency department
    - 24: ambulatory surgery center (ASC)
    - 25: birthing center

- Complete list of codes: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Box 24C:
- Not required

Box 24D:
- Required field
- Enter the appropriate procedure code(s) and modifier(s)
  - Do not include NDC number when billing for immunizations or injectable medications unless using an unspecified HCPCS drug code
  - Multiple units of same lab code should be billed on one line with multiple units vs each unit on a separate line
  - Telehealth services must be billed with a GT modifier
- Common errors:
  - Missing, invalid or incorrect usage of modifiers

Box 24E:
- Required field
- Enter the corresponding alpha characters from box 21 to indicate the appropriate diagnosis code(s) for a service
- Common errors:
  - Not attributing every diagnosis code to at least one service

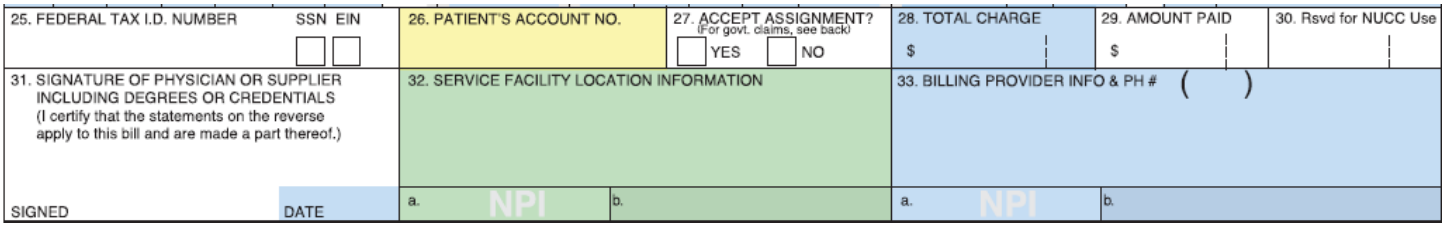
Box 24F:
- Required field
- Enter the total charge for each line item

Box 24G:
- Required field
- Enter the number of units billed for each line item

Box 24H:
- Not required

Box 24I:
- Required field
- If rendering provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area

Box 24J:
- Required field
- Enter the individual NPI for the provider who rendered each service
  - In a group setting, multiple rendering providers may be billed on the same claim form



Box 25:

- Not required

Box 26:

- Optional
- If an account number is entered in this field, it will be reported on the remittance advice

Box 27:

- Not required

Box 28:

- Required field
- When a paper claim is submitted with more than six lines of service, the total amount billed should be entered in box 28 on the last page of the claim. The word “continued” should be entered in box 28 on all preceding pages.
- Common errors:
    - Reducing the total by the amount paid by a primary payer
    - Entering a “balance due” amount instead of the total charge

Boxes 29 & 30:

- Not required

Box 31:

- Signature is NOT required
- Date IS required
- Only the date is required as the signature is already on file with Blue Cross Blue Shield of Kansas

Boxes 32 & 32a:

- Required, if applicable
- Box 32: Enter name, address, city, state, and zip code of the location where the services were rendered
- Box 32a: Enter NPI for location listed in box 32
    - Entity must be an external organization to the billing provider

Boxes 33 & 33a:

- Required fields
- Box 33: Enter provider, group, or supplier billing name, address, city, state, zip code, and phone number
    - If rendering provider is part of a group, enter group information
- Box 33a: Enter provider, group, or supplier NPI
    - If rendering provider is part of a group, enter group NPI
- Common errors:
    - Entering individual provider information when rendering provider is tied to a group
    - Entering group information when rendering provider is not tied to a group