

HCFA-1500 to CMS-1500 Paper Claim Form changes



MVP Health Care has developed this guide to help orient you to the key data fields that are changing on the new CMS-1500 Paper Claim Form that will be accepted by MVP Health Care starting 10/1/06 and mandatory beginning 4/1/07. The following example illustrates the changes between the HCFA-1500 claim form and the MVP Health Care data requirements on the new CMS-1500 paper claim form.

CMS-1500 Claim Form page 1

HCFA-1500 Claim Form page 1

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER
 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No., Street)
 6. PATIENT RELATIONSHIP TO INSURED
 7. INSURED'S ADDRESS (No., Street)
 8. PATIENT STATUS
 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
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
 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 PHYSICIAN OR OTHER SOURCE
 17a. NUMBER OF REFERRING PHYSICIAN
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
 19. RESERVED FOR LOCAL USE
 20. OUTSIDE LAB? \$ 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.
 23. PRIOR AUTHORIZATION NUMBER
 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS POINTER F. G. DAYS OF SERVICE OR UNITS H. I. ID. QUAL. J. RENDERING PROVIDER ID. #
 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER
 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT'S ADDRESS (No., Street)
 6. PATIENT RELATIONSHIP TO INSURED
 7. INSURED'S ADDRESS (No., Street)
 8. PATIENT STATUS
 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
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
 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 PHYSICIAN OR OTHER SOURCE
 17a. NPI
 17b. NPI
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
 19. RESERVED FOR LOCAL USE
 20. OUTSIDE LAB? \$ 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.
 23. PRIOR AUTHORIZATION NUMBER
 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS POINTER F. G. DAYS OF SERVICE OR UNITS H. I. ID. QUAL. J. RENDERING PROVIDER ID. #
 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) 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 #

NEW USAGE

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NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0009 FORM CMS-1500 (08-05)

MVP Health Care Data Field Changes on CMS-1500 Paper Claim Form

CMS-1500 Box	Submission Requirement
Box 24a-h Shaded Lines	Use the shaded lines above the service lines for: <ul style="list-style-type: none"> Anesthesia start/stop times Other service line information (e.g. descriptions for unspecified codes)
Box 24i*	Use the shaded space above "NPI" to report qualifier ZZ when reporting Rendering Taxonomy in the shaded space in the top half of Box 24j
Box 24j*	Use the shaded space above the NPI to report Rendering Taxonomy
Box 33a	NPI
Box 33b	Taxonomy code (preceded by ZZ qualifier)

In addition to MVP Health Care's field data requirement changes, the new CMS-1500 Paper Claim Form includes changes from CMS that do not directly affect your submissions to MVP Health Care, but about which we want you to know. Visit the National Uniform Claim Committee (NUCC) Web site for:

Log of CMS-1500 Changes:
http://www.nucc.org/images/stories/PDF/final_1500_change_log.pdf

CMS-1500 Instruction Manual:
http://www.nucc.org/images/stories/PDF/claim_form_manual_v1-3_7-06.pdf

NEW USAGE