BlueCross BlueShield of Montana

CMS-1500 Form

User Guide for Professional Providers

This guide will help you complete the CMS-1500 (Version 02/12) form when submitting claims to Blue Cross and Blue Shield of Montana.

To learn more about the CMS-1500 form, see the National Uniform Claim Committee's instruction manual.

Mail Paper Commercial Claims to:

Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

Mail Initial Paper Medicare Claims to:

Blue Cross Medicare Advantage
C/O Claims Department
PO Box 3686
Scranton, PA 18505

Electronic Claim Submission Is Preferred

Please only submit paper claims if necessary. Electronic claim submission is preferred on Availity® Essentials. For more information, our Claim Submission webpage.

To Order CMS-1500 Forms

- Visit the U.S. Government Bookstore, or
- Call the U.S. Government Printing Office at **1-866-512-1800**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medica) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | 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. OTHER CLAIM ID (Designated by NUCC)

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. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

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.

KEY

R REQUIRED IN FILING A BLUE CROSS CLAIM
S SITUATIONAL – ONLY IF APPROPRIATE TO THIS CLAIM
NR NOT REQUIRED/NOT USED

1. TYPE OF HEALTH INSURANCE COVERAGE R
Select "Other" to indicate that you are submitting a Blue Cross and Blue Shield Plan claim.

1a. INSURED ID NUMBER R
Enter the subscriber's identification number from their BCBS ID card.

2. PATIENT'S NAME R Last name, First name, Middle initial
Enter the patient's last name, first name and middle initial.

3. PATIENT'S BIRTH DATE/SEX R
Enter the patient's date of birth using the eight-digit date format (MM/DD/CCYY).
Next, select the patient's gender.

4. INSURED'S NAME R Last name, First name, Middle initial
Enter the insured's last name, first name and middle initial.

5. PATIENT'S ADDRESS/TELEPHONE NUMBER R
Enter the patient's permanent mailing address and telephone number.

6. PATIENT'S RELATIONSHIP TO THE INSURED R
Select the appropriate box for patient's relationship to the insured person.

7. INSURED'S ADDRESS/TELEPHONE NUMBER S
Enter the insured person's permanent mailing address (complete if different from the patient's address)

8. RESERVED FOR NUCC USE NR

9. OTHER INSURED'S NAME S
Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.

9a. OTHER INSURED'S POLICY OR GROUP NUMBER S
Enter the other insured person's policy or group number.

9b. RESERVED FOR NUCC USE NR
Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY).

9c. RESERVED FOR NUCC USE NR
Enter the other insured person's employer or school name.

9d. INSURANCE PLAN NAME OR PROGRAM NAME S
Enter the name of the other insured person's insurance plan or program name.

10a-d IS PATIENT'S CONDITION RELATED TO:
For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.

10a. Select whether the patient's condition is related to employment. S

10b. Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation, i.e. MT. S

10c. Select whether the patient's condition is related to any other type of accident. S

10d. CLAIM CODES (DESIGNATED BY NUCC) NR

(11 thru 11d, refer to BCBS subscriber coverage)

11. INSURED'S POLICY GROUP OR FECA NUMBER R
Enter the subscriber's group number from their BCBS ID card.

11a. INSURED'S DATE OF BIRTH, SEX R
Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.

11b. OTHER CLAIM ID (DESIGNATED BY NUCC) NR
Enter the subscriber's employer or school name.

11c. INSURANCE PLAN NAME OR PROGRAM NAME R
Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of Montana.

11d. IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN R
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE NR
Not required in filing BCBS claims.

13. INSURED OR AUTHORIZED PERSON'S SIGNATURE NR
Not required in filing BCBS claims.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) R
Enter the date using an eight-digit date format (MM/DD/CCYY).

15. OTHER DATE S
Enter the date using an eight-digit date format (MM/DD/CCYY).

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION S
Enter the date using an eight-digit date format (MM/DD/CCYY).

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE S
Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required only if there is a referring, ordering or supervising provider.

17a. OTHER ID# NR
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

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

18. HOSPITAL DATES RELATED TO CURRENT SERVICES S
Enter the hospital dates using an eight-digit date format (MM/DD/CCYY).

19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC) NR
Not required in filing BCBS claims.

20. OUTSIDE LAB/CHARGES NR
Select "Yes" or "No" to indicate if the claim includes charges for lab services performed outside of the physician's office. If "Yes," enter the total charges.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY R
Enter the ICD-10-CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional ICD-10-CM codes can be entered.

22. RESUBMISSION NR
Not required in filing BCBS Claims.

23. PRIOR AUTHORIZATION NUMBER NR
Not required in filing BCBS Claims.

24. SHADED AREA – SUPPLEMENTAL INFORMATION –
The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee's website at www.nucc.org.

24a. DATE(S) OF SERVICE R
Enter the dates of service using an eight-digit date format (MM/DD/CCYY).

24b. PLACE OF SERVICE R
Enter the appropriate two-digit Place of Service code.

24c. EMG S
If this service was an emergency, enter "Y" for "Yes," or leave blank if "No".

24d. PROCEDURES, SERVICES, OR SUPPLIES R
Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable.

24e. DIAGNOSIS POINTER R
Enter the appropriate ICD-10-CM diagnosis code or codes for each procedure performed. Enter one code per line of service.

24f. CHARGES R
Enter the charge for each line of service. Do not include discounts.

24g. DAYS OR UNITS R
Enter the number of days or units for each line of service.

24h. EPSDT/FAMILY PLAN S
If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code.

24i. ID QUALIFIER - SHADED FIELD NR
Not required, reserved for taxonomy code qualifier, "ZZ."

24j. RENDERING PROVIDER ID.
 # SHADED FIELD NR
Not required, reserved for taxonomy code.
NON-SHADED FIELD R
Enter the performing provider's 10-digit NPI number in the non-shaded area.

25. FEDERAL TAX ID NUMBER R
Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.

26. PATIENT ACCOUNT NUMBER S
Enter account number assigned to the patient, if applicable.

27. ACCEPT ASSIGNMENT R
Select "Yes" if the provider should be paid, or select "No" if the patient should be paid.

28. TOTAL CHARGE R
Enter the total charge for all services (total of all charges in 24f).

29. AMOUNT PAID S
Enter any amount paid by the patient only. Do not enter any amount by Medicare or other insurance.

30. RSVD FOR NUCC USE NR NR
Enter the difference, if any, between the total charge and the amount paid.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS R
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).

32. SERVICE FACILITY LOCATION INFORMATION S
Enter the location where the services were rendered. Required if the service location address is different than the billing address.

32a. NPI S
Enter the 10-digit NPI number of the service facility location.

32b. OTHER ID# S
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

33. BILLING PROVIDER INFO AND PH# R
Enter the information of the billing provider or supplier to be paid for services.

33a. NPI R
Enter the 10-digit NPI number of the billing provider.

33b. OTHER ID# S
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

Place of Service Codes

For information on Place of Service Codes, see the Centers for Medicare & Medicaid Services Place of Service Code Set.

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes for drugs
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ	Narrative description of unspecified code
N4	National Drug Codes
CTR	Contract rate
JP	Universal/National Tooth Designation System
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

For additional information for reporting NDC units, see the National Uniform Claim Committee's website.

Reminders

Complete all required fields. Be sure to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, ZIP code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims, but there are major advantages to submitting electronic claims:

- You may reduce your overhead. Electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in BCBSMT's system just the way they leave your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

For more information on electronic claim filing, email ecommerceservicesMT@bcbsmt.com or visit the Electronic Commerce webpage on our Provider website.