

PBH

CMS 1500 Billing Instructions

Medicaid requires that certain services be billed on a CMS 1500 billing form. Please see instructions below:

Box 1- Insurance Type: The information in this box is automatically populated from the billing system.

Box 1a - Insured's Social Security Number: The information in this box is automatically populated from the billing system.

Box 2- Patient's Name: The information in this box is automatically populated from the billing system.

Box 3 - Patient's Sex: The information in this box is automatically populated from the billing system.

Box 4- Insured Name: This will be auto populated with the primary policy holder's name.

Box 5- Patient's Address: The information in this box is automatically populated from the billing system.

Box 6- Patient's Relationship to Insured: This field will be auto populated with self as the selected relationship to the insured. This field can be changed to reflect the correct relationship if applicable.

Box 7- Insured's address: This information is automatically populated from the billing system.

Box 8 – Patient Status: This field has two required questions. The first question asks for the marital status of the patient. If unknown, select “other” from the drop down menu. Otherwise, select the appropriate marital status for the patient. The second question asks about the patient's employment status. Select the best option from the drop down menu.

Box 9 (a-d) – Other Insured Name: Fill in the policyholder's name, policy number, Insurance Company's name, (use the drop down menu to select), policyholder's date of birth, sex, employer/school name. Make sure to select “yes” from the drop down menu in box 11d. If the patient has no secondary insurance, leave these fields blank.

Box 10- Patient Condition Sources: This box has three fields that must be addressed. They each ask if the patient's medical condition is a result of an accident that occurred during employment, as a result of an auto accident, or as a result of another type of accident. If applicable, select “yes”, otherwise select “no” from the drop down menu.

Box 11- Insured's Policy Number: The information in this box is automatically populated from the billing system.

Box 11a- Insured's Date of Birth/Sex: The information in this box is automatically populated from the billing system.

Box 11b – Employer's/School's Name: If applicable, fill in the name of the patient's employer or school.

Box 11c – Insurance Plan: If applicable, fill in the insurance plan or program name.

Box 11d – Secondary Insurance Inquiry: If the patient has secondary insurance, select "yes" from the drop down menu and proceed to complete boxes 9-9b. If there is not secondary insurance, select "no" from the drop down menu.

Box 12 – Patient Signature on File: Indicate whether the patient has signed permitting release of medical billing information for reimbursement purposes. The first field in this box will be populated to the "Yes" selection. The field next to the signature indicates the date the patient signed the release. If this date is not known, use the earliest billing date available. Dates must be entered in the eight digit form, mm/dd/yyyy.

Box 21 – Diagnosis Code(s): Enter the diagnosis code(s) beginning with the primary diagnosis. Remember to key diagnosis code(s) accurately including all decimal places.

Box 22- Resubmission, Replacement, Void Claims: Enter the PBH resubmission (10) or replacement (11) number, or void number (12) and the original PBH claim number found on your remittance advice relative to the claim that was paid or denied.

Box 23- Prior Authorization Number: This is an optional field. If you chose to populate this field enter the 10 digit authorization number for the services being billed.

Box 24a – Service Date Span: Enter the eight digit service begin date in the "From" box and the eight digit service end date in the "To" box. *Note: All dates must be entered in the mm/dd/yyyy format.*

Box 24b- Place of Service: Enter the appropriate code from the drop down menu. The "Place of Service Crosswalk" is located in the Provider Direct Manual on the PBH website.

Box 24d- Service Code (and Modifier, if applicable): Enter the appropriate 5 digit CPT/HCPCS code to indicate the services provided. If the service requires a modifier, enter the modifier in the smaller box located to right of where you entered the Service Code.

Box 24e- Diagnosis Code Reference: Use this box to indicate which diagnosis codes were relevant to the line of service. Use the digits; 1 2 3 4 to designate specific diagnoses from box 21.

Example: To indicate that the line of service was medically necessary due to the first two diagnoses entered in box 21, key in "12". This signifies that both the first and second diagnosis were relevant to the service provided. If the first three diagnoses were considered when administering service, key in a "123"

Box 24f- Charges: Enter the usual and customary charge for each service provided. Enter the **total** charge for all units of each specific service as opposed to the charge per unit.

Box 24g- Service Days/Units: Enter the number of units provided for each individual service entered in box 24d on the claim form.

Box 24j - Rendering NPI: Enter the rendering provider's NPI, degree and select the appropriate taxonomy code from the drop down menu.

Box 24h & 24i - COB Payment: If applicable, enter the amount of the secondary insurance payment. If the secondary insurance denies the claim, enter a payment of \$0.00 in the field. Enter the COB reason code that best describes the basis of termination of benefits in the field to the right of the COB payment, box 24i. That box is labeled "COB reason".

****If necessary, add additional billing lines by typing in the number of lines you will need into the box that prompts for this. Make sure that all services are represented on their own line. ****

Box 25- Federal Tax ID: The information in this box is automatically populated from the billing system.

Box 26 – Patient Account Number: This field is **optional** and is reserved for the number assigned **by** the provider to facilitate retrieval, tracking, and filing of patient's account (receivables).

Box 28 – Total Charges: The system will automatically populate this field with the total charge of the lines from box 24

Box 29 – Amount Paid: Indicate any first party payments.

Box 30 – Balance Due: The system will automatically populate this field.

Box 31 – Physician/Supplier Signature: Check the electronic signature box to indicate that the physician/supplier has signed off on the services billed for. Provide the date the billing was signed off for underneath the electronic signature box

Box 32 – Service Facility Location: The information in this box is automatically populated from the billing system.

Box 33 – Billing Provider: The information in this box is automatically populated from the billing system.

Once you have completed all required fields, click “Save”. Once you click “Save”, if you have made any syntax errors you will be notified at the top of the page in **RED**. *You will NOT be able to save your claim unless all errors are addressed and corrected.*

If you have not received syntax error messages, you can now save your claim and review prior to submission. If changes must be made, click “*Edit*” to return. If all information is correct, click “*Submit*” to enter the claim into the PBH billing system for processing. You may wish to print your submitted claim for your records.

CMS 1500 Cheat-Sheet

	Box Number	Description	Info Required
1	Box 1-7	Name, dob, sex, address etc	The information is automatically populated from the billing system.
2	Box 8	Patient Status	Choose marital status; employment (this box consists of two drop downs to be populated)
3	Box 9	Other insured's Name	If applicable, enter private insurance information. (Only if service being claimed is also billable to third party carrier/this would also include boxes 9a-9d)
4	Box 9a	Other Insurance Policy or Group #	If applicable, enter private insurance information.
5	Box 9a	Insurance company Name	Choose insurance company from the drop-down. Note: other is not listed in the drop down as a selection & the field is not a free text.
6	Box 9b	Other Insured's DOB/Sex	If applicable, enter private insurance information.
7	Box 9c	Employer's or School Name	If known
8	Box 9d	Insurance Company Name/ Payer ID	Only if you have selected "other" under drop-down 9a
9	Box 10	Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident?	Check the appropriate answers in the three dropdown boxes.
10	Box 11	Insurance ID	Pre-populated
11	Box 11a	Insured's DOB/Sex	Pre-populated
12	Box 11b	Employer's or School Name	If Applicable
13	Box 11c	Insurance Plan or Program Name	If Applicable
14	Box 11d	Is there another health benefit plan?	Choose yes or no from the drop-down.
15	Box 12	Patient signed/Date	Choose appropriate answer from pull-down box and enter date. (date format is always 00/00/0000)
16	Box 21	Diagnosis Codes	ICD-9-CM coded to describe the primary diagnosis. (If code is more than three digits remember to include decimal point)
17	Box 22	Resubmission, Replacement, Void Claims	Enter the PBH resubmission or replacement number (10), or void number (12) and the original PBH claim number found on your remittance advice where the claim was paid or denied as the reference number.
18	Box 23	Prior Authorization #	Optional - Enter the appropriate 10 digit authorization number.
19	Box 24a	Date(s) of Service "From" and "To"	Enter the 8-digit dates of service. Format: 00/00/0000
20	Box 24b	Place of Service	Enter the appropriate code from the drop down box. "Place of Service Crosswalk" is located in the Provider Direct Manual on the PBH website.
21	Box 24d	Service Code	Enter the appropriate 5-digit CPT/HCPCS code. If service

		Modifier (If Applicable)	requires a modifier enter it in the next box.
22	Box 24e	Diagnosis Code	Enter 1, 2, 3 or 4 from box 21 to indicate the appropriate diagnosis for the service being delivered.
23	Box 24f	Charges	Enter the usual and customary charge for each service rendered.
24	Box 24g	Days or Units	Enter the number of visits or units applicable to the service being billed.
25	Box 24h	COB Payment	If applicable
26	Box 24i	COB Reason	If applicable
27	Box 24j	Rendering Provider ID Number	Enter rendering provider's NPI number and Taxonomy Code.
28	Box 25	Federal Tax ID/Type	Hard coded
29	Box 26	Patient Account Number	Optional: Patient Account number from Provider (by using your own internal patient tracking number you will have the ability to refer back to it on the remittance advice for reconciliation).
30	Box 28	Total Charges	Calculated by the system (Box 29 – Any first party payments)
31	Box 29	Amount Paid	Enter any first party payments.
32	Box 30	Balance Due	Calculated by system.
33	Box 31	Sign & Date	Check the signed box and date (electronic signature)
34	Box 32	Service Render Facility	Hard coded
35	Box 33	Physician or Supplier's Billing Name, Address, Zip & Phone #	Hard coded