CMS-1500 Claim Form Completion for PROMISe™ Behavioral Health Rehabilitation Services (BHRS) Providers

Purpose of the document	The purpose of this document is to provide a block-by-block reference guide to assist the following provider specialties in successfully completing the CMS-1500 claim form: • **Therapeutic Staff Support (TSS)** • **Mobile Therapy (MT)** • **Behavioral Specialist Consultant (BSC)** • **Behavior Specialist for Children with Autism (BSC-ASD)**

Document format	This document contains a table with four columns. Each column provides a specific piece of information as explained below:
	• **Block Number** – Provides the block number as it appears on the claim.
	• **Block Name** – Provides the block name as it appears on the claim.
	• **Block Code** – Lists a code that denotes how the claim block should be treated. They are:
	  • **M** – Indicates that the claim block must be completed.
	  • **A** – Indicates that the claim block must be completed, if applicable.
	  • **O** – Indicates that the claim block is optional.
	  • **LB** – Indicates that the claim block should be left blank.
	  • *** –** Indicates special instruction for block completion.
	• **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.
	**********
	The following restrictions apply:
	• When the procedure code and modifier(s) are authorized on the Prior Authorization Notice for **Therapeutic Staff Support** services, they must be provided in two unit increments.
	• Assessment and Assistance services - provide a minimum of four units and in increments of four units.
	• Mobile Therapy services - provide a minimum of two units and in increments of two units.

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IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use blue or black ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, do not use decimal points and be sure to enter dollars and cents:

1. Block 24F ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24F, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is sixty-five dollars, enter:

24F	
$CHARGES	
65	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

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Ordering and Prescribing

The Patient Protection and Affordable Care Act (ACA) added requirements for provider screening and enrollment, including a requirement that states require physicians and other practitioners who order or refer items or services for MA beneficiaries to enroll as MA providers. The Department of Health and Human Services regulation implementing this requirement can be found at 42 CFR § 455.410.

Claims submitted by the following provider types and specialties must include the NPI of the MA enrolled ordering or prescribing provider:

08-800 Federally Qualified Health Center (FQHC) Therapeutic Staff Support;
08-801 FQHC Mobile Therapy;
08-802 FQHC Behavioral Specialist Consultant;
08-804 Rural Health Clinic (RHC) Therapeutic Staff Support;
08-805 RHC Mobile Therapy ;
08-806 RHC Behavioral Specialist Consultant;
08-808 Psych Outpatient Therapeutic Staff Support;
08-809 Psych Outpatient Mobile Therapy;
08-810 Psychiatric Outpatient Behavioral Specialist
08-558 Behavioral Specialist for Children with Autism

09-548 Therapeutic Staff Support
09-549 Mobile Therapy
09-558 Behavioral Specialist for Children with Autism
09-559 Behavioral Specialist Consultant

11-442 Part Psych Hospital Child Therapeutic Staff Support
11-443 Part Psych Hospital Child Mobile Therapy
11-444 Part Psych Hospital Child Behavioral Specialist Consultant
11-446 Part Psych Hospital Adult Therapeutic Staff Support
11-447 Part Psych Hospital Adult Mobile Therapy
11-448 Part Psych Hospital Adult Behavioral Specialist Consultant
11-450 Family Based Mental Health Therapeutic Staff Support
11-451 Family Based Mental Health Mobile Therapy
11-452 Family Based Mental Health Behavioral Specialist Consultant
11-548 Therapeutic Staff Support
11-549 Mobile Therapy
11-558 Behavioral Specialist for Children with Autism
11-559 Behavioral Specialist Consultant

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19-548 Therapeutic Staff Support
19-549 Mobile Therapy
19-558 Behavioral Specialist for Children with Autism
19-559 Behavioral Specialist Consultant

31-548 Therapeutic Staff Support
31-549 Mobile Therapy
31-558 Behavioral Specialist for Children with Autism
31-559 Behavioral Specialist Consultant

Providers should refer to block 17, 17a, and 17b for further instructions.

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You must follow these instructions to complete the CMS-1500 claim when billing Medical Assistance. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	O	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.
3	Patient's Birthdate and Sex	O	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.

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Block No.	Block Name	Block Code	Notes
8	Reserved for NUCC Use	LB	Do not complete this block.
Please note that Blocks 9, 9a and 9d are used to indicate **Secondary** insurance information. For example, if a beneficiary has Aetna, Blue Shield, and Medical Assistance, the information regarding Aetna (the primary payer) would be placed in Blocks 11, 11a, 11c and 11d. The information regarding Blue Shield (the secondary payer) would be placed in Blocks 9, 9a and 9d.			
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy or Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a–d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Reserved for NUCC Use	LB	Do not complete this block.
9c	Reserved for NUCC Use	LB	Do not complete this block.
9d	Insurance Plan Name or Program Name	A	Enter the other insured's insurance plan name or program name.
10a–10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's 2-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for

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Block No.	Block Name	Block Code	Notes
			Pennsylvania).
10d	Claim Codes (Designated by NUCC)	O	Enter the 9-digit social security number of the policyholder if the policyholder is not the beneficiary.
Please note that Blocks 11, 11a, 11c and 11d are used to indicate **Primary** insurance information. For example, if a beneficiary has Aetna and Medical Assistance, the information regarding Aetna (the primary payer) would be placed in Blocks 11, 11a, 11c and 11d. If the beneficiary has two other insurance plans, for example, Aetna, Blue Shield, and Medical Assistance, the information regarding Aetna would be placed in Blocks 11, 11a, 11c and 11d and the Blue Shield (the secondary payer) information would be placed in Blocks 9, 9a, and 9d.			
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The beneficiary's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) **Note:** Please refer to Section 6 of the PA PROMISe™

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Block No.	Block Name	Block Code	Notes
			Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current Illness, Injury or Pregnancy (LMP)	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).
15	Other Date	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Provider or Other Source	M	Enter the name of the prescribing provider.
17a	I.D. Number of Referring Provider	M	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number In the second portion, enter the **license number** of the prescribing provider named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456).

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Block No.	Block Name	Block Code	Notes
17b	NPI #	M	Enter the NPI of the prescribing provider named in block 17.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Additional Claim Information (Designated by NUCC)	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**", followed by a two-digit number (i.e., **AT05**). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**", indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form MA 539 . When using "**AT10**", indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form MA 538. Attachment Type Code "**AT99"** indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary's number on the top left-hand corner of the page (i.e., Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's beneficiary number. On the remarks sheet, include the mother's full name, date of birth, and social security number.). If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. For a complete listing and description of Attachment Type

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Block No.	Block Name	Block Code	Notes
			Codes, please refer to the *CMS-1500 Claim Form Desk Reference*, located in Appendix A of the handbook. *For additional information on completing CMS-1500 claim form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*
		A	**Qualified Small Businesses** Qualified small businesses must always enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
***Note:** If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.			
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	The ICD indicator (ICD Ind) is required. If a valid "9" or "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete. For dates of service **prior** to October 1, 2015, enter the most specific ICD-9-CM code (indicator "9"); **OR** for dates of service **on or after** October 1, 2015, enter the ICD-10-CM code (indicator "0") that describes the diagnosis. The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.
22	Resubmission Code	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit

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Block No.	Block Name	Block Code	Notes
			internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the two-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	A/M	Enter the 10-digit authorization number, when applicable. TSS requires a Prior Authorization approval. **(Must)** **Prior Authorization and Program Exception (PE.)** – If services were approved through PA or PE, the authorization number must be entered in this block. **Do not include prior authorized services on the same claim with services that do not require prior authorization**. Failure to follow this instruction will cause your claim(s) to deny. Refer to Section 7 of the CMS-1500 Provider Handbook for additional information regarding prior authorization for your specific provider type.
24a	Date(s) of Service	M/M	Enter the date in an 8-digit format (MMDDCCYY) in the "**From** or **To**" portion of this block (not both). If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an 8-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.
24b	Place of Service	M	Enter the 2-digit place of service code that indicates where the service was performed. **Therapeutic Staff Support (TSS)** **12** – Home

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Block No.	Block Name	Block Code	Notes
			23 – Emergency Room **99** – Community **Behavioral Specialist Consultant (BSC) and Behavior Specialist for Children with Autism (BSC-ASD)** **11** – Office **12** – Home **23** – Emergency Room **50** – Federally Qualified Health Center (FQHC) **72** – Rural Health Clinic (RHC) **99** – Community **Mobile Therapy (MT)** **12** – Home **99 -** Community
24c	EMG	A	Enter **1** if the service provided was in response to an emergency, **2** if urgent. Otherwise, leave this item blank.
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/AAAA	List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to three additional informational modifiers when applicable. If no pricing modifier is required, enter up to 4 additional/informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial. .
24e	Diagnosis Pointer	M	This block may contain up to four letters. Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21. If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary

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Block No.	Block Name	Block Code	Notes
			diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis. **Note:** The primary diagnosis pointer must be entered first.
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24g	Days or Units	M	Enter the number of units, services, or items provided.
24h	EPSDT/Family Planning	A	Enter the 2-digit visit code, if applicable. Visit codes are especially important if providing services that do not require copay (e.g., for a pregnant beneficiary). Please note that beneficiary's under the age of 18 are exempt from copayment. A visit code is not necessary when submitting a claim for a beneficiary under the age of 18. *For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **G2** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	A	Enter the 10-digit NPI number of the rendering provider.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.

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Block No.	Block Name	Block Code	Notes
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to 10 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect beneficiary number is listed.
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	A	If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. **Do not enter copay in this block.**
30	Reserved for NUCC Use	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004).
32	Service Facility Location Information	LB	Do not complete this block.
32a		LB	Do not complete this block.
32b		LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
33	Billing Provider Info & Ph.#	A/A & M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)