

CMS-1500 Billing Guide for PROMISe™ Aging Waiver

Purpose of the document The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:

- **Aging Waiver Services**

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.
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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 negotiated rate is sixty-five dollars and you enter 65, your negotiated rate may be read as .65 cents.

Example #1: When completing Block 24F, enter your negotiated rate, without a decimal point. You must include the dollars and cents. If your negotiated rate is thirty-five dollars, enter:

24F	
\$CHARGES	
35	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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You must follow these instructions to complete the CMS-1500 claim when billing the Department of Human Services. **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. The 10-digit beneficiary number may be obtained from the Service Order received from the Area Agency on Aging (AAA).
2	Patient's Name	M	Enter the patient's last name, first name, and middle initial.
3	Patient's Birthdate and Sex	M	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.

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Block No.	Block Name	Block Code	Notes
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.
8	Reserved for NUCC Use	LB	Do not complete this block.
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 <u>and</u> 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.

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Block No.	Block Name	Block Code	Notes
10a–10c	Is Patient's Condition Related To:	LB	Do not complete this block.
10d	Claim Codes (Designated by NUCC)	LB	Do not complete this block.
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	Enter the words Signature Exception in this block. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 08012003) with no slashes, hyphens, or dashes.) Note: Providers must collect beneficiary signatures for each service delivered. If you do not have a form to collect the beneficiary's signature, you may use the

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Block No.	Block Name	Block Code	Notes
			Encounter Form (MA 91) contained in the Special Forms Section of the handbook.
13	Insured's or Authorized Person's Signature	LB	Do not complete this block.
14	Date of Current Illness, Injury or Pregnancy (LMP)	LB	Do not complete this block.
15	Other Date	LB	Do not complete this block.
16	Dates Patient Unable to Work in Current Occupation	LB	Do not complete this block.
17	Name of Referring Provider or Other Source	LB	Do not complete this block.
17a	I.D. Number of Referring Provider	LB	Do not complete this block.
17b	NPI #	LB	Do not complete this block.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Additional Claim Information (Designated by NUCC)	A/A	<p>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).</p> <p>Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,).</p> <p>DHS does not require that you attach insurance</p>

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Block No.	Block Name	Block Code	Notes
		A	<p>statements to the claim (<u>with the exception of Medicare claims</u>). (<u>If the beneficiary has Medicare and MA, see *note below.</u>) However, the number and type of statements on file is required, and the codes in this block provide that information.</p> <p>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.</p> <p>For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</p> <p><i>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.</i></p> <p>Qualified Small Businesses</p> <p>Qualified small businesses must <u>always</u> 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:</p> <p>“(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.”</p>
<p>*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.</p>			
20	Outside Lab?	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
21	Diagnosis or Nature of Illness or Injury	M/A	<p>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.</p> <p>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.</p>
22	Resubmission Code	A/A	<p>This block has two uses:</p> <ol style="list-style-type: none"> 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit 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 <u>LAST APPROVED</u> 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (e.g., ADJ 1103123523123 01).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Date(s) of Service	M/M	<p>Enter the date that the first authorized service or item was provided (as per the Care Plan). Use an 8-digit date (MMDDCCYY) format (e.g., 03012004). Do not use slashes, dashes, hyphens, or spaces.</p> <p>For PDA Waiver Program services rendered throughout the month, claims are to be submitted monthly. Providers are encouraged to complete and submit claims as soon as possible after the end of each calendar month.</p> <p>If you are providing a one time service, you need to</p>

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Block No.	Block Name	Block Code	Notes
			<p>enter the same date in Block 24A, “From” and “To”.</p> <p>Note: For environmental modifications or Personal Emergency Response Systems (PERS) installations, use the start date authorized on the Care Plan as your service “From” and “To” date.</p>
24b	Place of Service	M	<p>Enter the 2-digit place of service code that indicates where the service was performed.</p> <p>11 – Office 12 – Home 32 – Nursing Home 99 – Other (Community)</p>
24c	EMG	LB	Do not complete this block.
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	<p>List the procedure code(s) for the service(s) being rendered and any applicable modifier(s).</p> <p>In the first section of the block, enter the procedure code that describes the service provided.</p> <p>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 four 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.</p> <p>Note: The AAA Service Order will contain the procedure code or procedure code and modifier(s) for completion of this block.</p>

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Block No.	Block Name	Block Code	Notes
24e	Diagnosis Pointer	M/A	<p>This block may contain up to four letters.</p> <p>Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21.</p> <p>If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis.</p> <p>Note: The primary diagnosis pointer must be entered first.</p>
24f	\$Charges	M	<p>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.</p>
24g	Days or Units	M	<p>Enter the number of units, services, or items provided.</p> <p>Note: The number of units in this block cannot exceed the number of units listed on the AAA Service Order.</p>
24h	EPSDT/Family Planning	LB	<p>Do not complete this block.</p>
24i	ID Qualifier	A	<p>Enter the two-digit ID Qualifier: G2 = 13-digit Provider ID Number (legacy #)</p>
24j (a)	Rendering Provider ID #	A	<p>Complete with the Rendering Provider's Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total).</p> <p>Note: Only one rendering provider per claim form.</p>
24j (b)	NPI	A	<p>Enter the 10-digit NPI number of the rendering provider.</p>
25	Federal Tax I.D. Number	M	<p>Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an X in</p>

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Block No.	Block Name	Block Code	Notes
			the appropriate block.
26	Patient's Account Number	M	Enter your own reference to your patient. 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	LB	Do not complete 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	A/LB	If the service(s) was provided in a long term care facility, enter <u>only</u> the name of the facility.
32a		A	Enter the 10-digit NPI number of the service facility.
32b		M/A	Enter the 13-digit facility Provider ID number (Legacy #)

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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		A	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)