

CMS-1500 Billing Guide for PROMISe™ Office of Developmental Program (ODP) Base Services & P/FDS & Consolidated Waiver Services

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:

- **Office of Developmental Programs (ODP) Base & P/FDS & Consolidated Waiver**

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 or refer to the CMS-1500 Handbook for further clarification.

Special Notes TSM (T1017) and Waiver Case Management Services (W7210) may not be billed directly through PROMISe™. These must be billed through HCSIS. PROMISe™ providers must submit original CMS-1500 Claim Form (invoice) for processing. **Photocopies of the CMS-1500 are not acceptable and will not be processed.**

When a photocopy is received, the mailroom will attach a letter to the CMS-1500 and return it to the provider with a letter explaining that a billable service(s) must be submitted on an original claim form.

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

Example #1: When completing Block 24F, enter your county negotiated rate, without a decimal point. You must include the dollars and cents. If your county 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 Public Welfare. **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. Note: If an X is not placed in the Medicaid box, your claim will not be processed.
1a	Insured's ID Number	M	Enter the 10-digit recipient number found on the recipient's ACCESS card. If the recipient number is not available, access the Eligibility Verification System (EVS) by using the recipient's Social Security Number (SSN) and date of birth (DOB). The EVS response will provide the 10-digit recipient number to use for this block.
2	Patient's Name	O	Enter the recipient's last name, first name, and middle initial.
3	Patient's Birthdate and Sex	LB	Do not complete this block.
4	Insured's Name	LB	Do not complete this block.
5	Patient's Address	LB	Do not complete this block.
6	Patient's Relationship to the Insured	LB	Do not complete this block.
7	Insured's Address	LB	Do not complete this block.
8	Patient Status	LB	Do not complete this block.
9	Other Insured's Name	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
9a	Other Insured's Policy and Group Number	LB	Do not complete this block.
9b	Other Insured's Date of Birth and Sex	LB	Do not complete this block.
9c	Employer's Name or School Name	LB	Do not complete this block.
9d	Insurance Plan Name or Group Name	LB	Do not complete this block.
10a–10c	Is Patient's Condition Related To:	LB	Do not complete this block.
10d	Reserved For Local Use	LB	Do not complete this block.
11	Insured's Policy Group or FECA Number	LB	Do not complete this block.
11a	Insured's Date of Birth and Sex	LB	Do not complete this block.
11b	Employer's Name or School Name	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
11d	Is There Another Health Benefit Plan?	LB	Do not complete this block.
12	Patient's or Authorized Person's Signature and Date	M/M	The recipient's signature or the words Signature Exception must appear in this field. Also, enter the date of claim submission in an eight-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.)
13	Insured's or Authorized Person's Signature	LB	Do not complete this block.
14	Date of Current:	LB	Do not complete this block.
15	If Patient Has Had Same or Similar Illness	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 Physician or Other Source	LB	Do not complete this block.
17a	I.D. Number of Referring Physician	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.

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Block No.	Block Name	Block Code	Notes
19	Reserved For Local Use	LB	Do not complete this block.
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	LB	Do not complete this block.
22	Medicaid Resubmission	A/A	<p>This block has two uses:</p> <ol style="list-style-type: none"> 1) 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) 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 two-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.

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Block No.	Block Name	Block Code	Notes
24a	Dates of Service	M/M	<p>Enter the applicable date(s) of service.</p> <p>If billing for a service that was provided on one day only, complete either the From or the To column (but not both.).</p> <p>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 eight-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.</p>
24b	Place of Service	M	<p>Enter the 2-digit place of service code that indicates where the service was performed.</p> <p style="text-align: center;">12 - Home</p> <p style="text-align: center;">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>
24e	Diagnosis Pointer	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
24f	\$Charges	M	Enter your county negotiated rate for the service(s) provided. For example, if your usual charge is thirty-five dollars, enter 3500 . If billing for multiple units of service, multiply your county negotiated rate by the number of units billed and enter that amount.
24g	Days or Units	M	Enter the number of units, services, or items provided.
24h	EPSDT/Family Planning	LB	Do not complete this block.
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: ID = 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. For Intermediate Service Organization (ISO) claims, enter the SSN of the direct care provider (subcontractor).
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 recipient'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 recipient number is listed.

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Block No.	Block Name	Block Code	Notes
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	A	If a recipient 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 recipient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. Do not enter copy in this block.
30	Balance Due	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 recipient'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 #)