

HOW TO COMPLETE THE CMS 1500 CLAIM FORM

Assisted Living Providers *Effective for dates of service on or after February 1, 2018*

Rev. 1/11/2018

The following is a step-by-step explanation of how to prepare the health insurance claim form, CMS 1500. Failure to properly complete MANDATORY requirements will cause the claim to be denied by South Dakota (SD) Medicaid. If submitting paper claims, please refer to <http://dss.sd.gov/medicaid/ocr.aspx> for claim form requirements.

BLOCK 1A INSURED'S ID NO. (MANDATORY)

The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.

BLOCK 2 PATIENT'S NAME (MANDATORY)

Enter the recipient's last name, first name, and middle initial.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)

1. Enter 0 for the ICD-10-CM indicator.
2. Enter the codes on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code.

BLOCK 22 RESUBMISSION CODE

1. Enter a 7 for an Adjustment; or an 8 for a Void.
2. List the original reference number found on your remittance advice. This number will always be 14 digits.

Note:

You cannot void or adjust one line on the claim. The void or adjustment will apply to the entire claim.

As of February 1, 2018 you may only void prior submitted UB claims. Once the claim is voided, please resubmit the charges on the CMS 1500 form.

BLOCK 24

Use a separate line for each date span. If billing on paper and more than six date spans were provided in a single calendar month then a separate claim form for the seventh and following services must be completed; continued claims are not accepted. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code.

24A. DATE OF SERVICE FROM – TO (MANDATORY)

Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion.

Example: FROM TO
100117 103117

Hospital reserve bed days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to SD Medicaid per hospitalization; however, the recipient must return to the ALC for a minimum of 24 hours before additional hospital reserve bed days will be paid. *Hospital reserve bed days must be billed with a code of 21 in 24B for the place of service.*

Therapeutic leave days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Assisted Living Center for non-medical reasons (e.g., visits to the homes of family or friends). *Therapeutic leave days must be billed with a code 12 in 24B for the place of service.*

Note:

Do not include the recipient’s date of discharge or date of death in the dates of service.

24B. PLACE OF SERVICE (MANDATORY)

Enter the appropriate place of service code.

Code values:

- 12 Home
- 13 Assisted Living Center
- 21 In-Patient Hospital

24D. PROCEDURE CODE (MANDATORY)

Enter the appropriate five character Healthcare Common Procedure Coding System (HCPCS) code for the approved service provided.

HCPCS Code	Description
T2031	Assisted Living

NOTE: Use the same procedure code only once per date of service.

24E. DIAGNOSIS POINTER (MANDATORY)

Enter A – L which correlates to the diagnosis code entered in Block 21.

24F. CHARGES (MANDATORY)

Enter the provider’s usual and customary charge for this service in the unshaded portion. For example, if the usual and customary charge is \$50.00 enter 50.00.

24G. DAYS OR UNITS (MANDATORY)

Enter the number of days that the service was provided for this recipient during the period covered by the dates in block 24A. The units must equal the date of service span.

24I. ID QUALIFIER (MANDATORY)

Enter ZZ.

24J. TAXONOMY AND RENDERING PROVIDER ID # (OPTIONAL)

1. Enter 310400000X Enter the ALC NPI number in the unshaded portion of the field or leave blank. This will be the same NPI that is used in 33A.

BLOCK 25 FEDERAL TAX ID NUMBER (MANDATORY)

The number assigned to the provider by the federal government for tax reporting purposes; also known as a tax identification number (TIN) or employer identification number (EIN).

BLOCK 28 TOTAL CHARGES (OPTIONAL)

Enter the sum of the charges in column 24F [lines 1 – 6]. For example, if the sum of the charges in 24F is \$1,500.00 enter 1500 00

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)

The claim must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without a signature and date completed.

BLOCK 33 PROVIDER NAME, ADDRESS AND ZIP CODE (MANDATORY)

Enter the billing provider's name and ALC address as shown on the SD MEDX Enrollment record.

33A. (MANDATORY): Enter the billing NPI number of the Assisted Living Center.

33B. (MANDATORY): Enter ZZ310400000X with no spaces.



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

CARRIER

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
1a. INSURED'S I.D. NUMBER 111111111
2. PATIENT'S NAME SMITH, JANE
3. PATIENT'S BIRTH DATE MM DD YY M F
4. INSURED'S NAME
5. PATIENT'S ADDRESS
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS
8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
15. OTHER DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. ADDITIONAL CLAIM INFORMATION
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
22. RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER

Table with 6 rows and multiple columns for service dates, charges, and NPI numbers.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER 111111111
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE \$ 1500.00
29. AMOUNT PAID
30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER John Doe 11-01-17
32. SERVICE FACILITY LOCATION INFORMATION WAIVER PLACE 123 HAPPY STREET PIERRE, SD 57501
33. BILLING PROVIDER INFO & PH #