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## CMS-1500 Billing Guide for PROMISe™ Nutritionists

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<b>Purpose of the document</b>	<p>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:</p> <ul style="list-style-type: none"><li>• <b>Nutritionist – Provider Type 23</b></li></ul>
<b>Document format</b>	<p>This document contains a table with four columns. Each column provides a specific piece of information as explained below:</p> <ul style="list-style-type: none"><li>• <b>Block Number</b> – Provides the block number as it appears on the claim.</li><li>• <b>Block Name</b> – Provides the block name as it appears on the claim.</li><li>• <b>Block Code</b> – Lists a code that denotes how the claim block should be treated. They are:<ul style="list-style-type: none"><li>• <b>M</b> – Indicates that the claim block must be completed.</li><li>• <b>A</b> – Indicates that the claim block must be completed, if applicable.</li><li>• <b>O</b> – Indicates that the claim block is optional.</li><li>• <b>LB</b> – Indicates that the claim block should be left blank.</li><li>* – Indicates special instruction for block completion.</li></ul></li><li>• <b>Notes</b> – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.</li></ul>

## **CMS-1500 Claim Form Completion for PROMISE™ Nutritionists**

### **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 fifteen dollars, enter:

24F	
\$CHARGES	
15	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.

<b>Block No.</b>	<b>Block Name</b>	<b>Block Code</b>	<b>Notes</b>
1	Type of Claim	M	Place an <b>X</b> 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	A	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.  <b>*This field is required when billing for newborns using the mother's beneficiary number.</b> Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl.
3	Patient's Birthdate and Sex	A	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 <b>X</b> in the appropriate box.  <b>*Same as the special instruction for Block 2.</b> Enter the newborn's date of birth in an eight-digit format.
4	Insured's Name	LB	Do not complete this block.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to Insured	LB	Do not complete this block.

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<b>Block No.</b>	<b>Block Name</b>	<b>Block Code</b>	<b>Notes</b>
7	Insured's Address	LB	Do not complete this block.
8	Reserved for NUCC Use	LB	Do not complete this block.
9	Other Insured's Name	LB	Do not complete this block.
9a	Other Insured's Policy or Group Number	LB	Do not complete this block.
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	LB	Do not complete this block.
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	LB	Do not complete this block.
11a	Insured's Date of Birth and Sex	LB	Do not complete this block.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.

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<b>Block No.</b>	<b>Block Name</b>	<b>Block Code</b>	<b>Notes</b>
11c	Insurance Plan Name or Program Name	LB	Do not complete this block.
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	<p>The beneficiary's signature or the words <b>Signature Exception</b> must appear in this field.</p> <p>Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.</p> <p><b>Note:</b> Please refer to Section 6 of the PA PROMISE™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.</p>
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	A	Enter the name and degree of the referring, supervising, attending, or prescribing practitioner, when applicable.

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Block No.	Block Name	Block Code	Notes
17a	I.D. Number of Referring Provider	A	<p>Enter the <b>license number</b> of the referring, supervising, attending, or prescribing practitioner 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).</p> <p>If an out-of-state provider orders the service, enter the 2-digit State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.</p>
17b	NPI#	M	Enter the 10-digit NPI number of the referring provider.
18	Hospitalization Dates Related to Current Services	A	<p>Complete only if the patient was hospitalized in an inpatient setting. Make sure the dates are in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).</p> <p>Providers may submit a bill prior to a patient's discharge by entering the admission date and eight zeros in the discharge date. If you submit an interim bill, submit the final claim for any remaining inpatient visits by completing the admission date and entering the actual discharge date.</p> <p><b>Note:</b> Consultants, radiologists, anesthesiologists may bill for their services before the patient is discharged. In this instance, enter eight (8) zeros for the discharge date.</p>
19	Additional Claim Information (Designated by NUCC)	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., <b>AT05</b>).</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>When using "AT05", indicating a Medicare payment, please remember to properly complete and <b>attach</b> the "Supplemental Medicare Attachment for Providers" form <a href="#">MA 539</a>.</p> <p>When using "AT10", indicating a payment from a</p>

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Block No.	Block Name	Block Code	Notes
			<p>Commercial Insurance, please remember to properly complete and <b>attach</b> the "Supplemental Attachment for Commercial Insurance for Providers" form <a href="#">MA 538</a>.</p> <p>Attachment Type Code “<b>AT99</b>” 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 <b>AT26, AT99</b> 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.).</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 <a href="#">CMS-1500 Claim Form Desk Reference</a>, 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>

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Block No.	Block Name	Block Code	Notes
		A	<p><b>Qualified Small Businesses</b></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><b>“(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.”</b></p>
<p><b>*Note:</b> 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 <b>AT05</b> in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to <a href="#">MA 539</a> for additional information.</p>			
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	A/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 <b>prior</b> to October 1, 2015, enter the most specific ICD-9-CM code (indicator “9”) <b>OR</b> for dates of service <b>on or after</b> October 1, 2015 enter the ICD-10-CM code (indicator “0”) that describes the diagnosis.</p> <p>The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.</p>
22	Resubmission Code	A/A	<p>This block has two uses:</p> <ol style="list-style-type: none"> <li>1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the <b>ORIGINAL</b> rejected claim in the right portion of this block (e.g.,   1103123523123).</li> <li>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 <b><u>LAST APPROVED</u></b> 13-digit ICN, a</li> </ol>

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Block No.	Block Name	Block Code	Notes
			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.
24a	Date(s) 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 <b>From</b> or the <b>To</b> column (but not both.).</p> <p>If the same service was provided on consecutive days, enter the first day of the service in the <b>From</b> column and the last day of service in the <b>To</b> 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 two-digit place of service code that indicates where the service was performed.</p> <p><b>11</b> – Office  <b>12</b> – Home  <b>22</b> – Outpatient Hospital  <b>99</b> – Other</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</p>

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Block No.	Block Name	Block Code	Notes
			portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.
24e	Diagnosis Pointer	M	<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	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 <b>6500</b> .
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	<p>Enter the two-digit ID Qualifier:</p> <p><b>G2</b> = 13-digit Provider ID Number (legacy #)</p>
24j (a)	Rendering Provider ID #	A	<p>Complete with the <b>Rendering Provider's</b> Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total).</p> <p><b>Note:</b> Only one rendering provider per claim form.</p>
24j (b)	NPI	M	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 <b>X</b> in the appropriate

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Block No.	Block Name	Block Code	Notes
			block.
26	Patient's Account Number	O	<b>Use of this block is strongly recommended.</b> 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, except for abortions, 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/A	If the service(s) was provided in an inpatient hospital, outpatient hospital, hospital short procedure unit, hospital special treatment room, ambulatory surgical center, or emergency room, enter the name, the nine-digit provider number, and the four-digit service location of the facility. If the service(s) was provided in a long term care facility, enter <u>only</u> the name of the facility.
32a		M	Enter the 10-digit NPI number of the service facility.
32b		M/A	Enter the 13-digit facility Provider ID number (Legacy #)
33	Billing Provider	A/A&	Enter the billing provider's name, address, and telephone

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<b>Block No.</b>	<b>Block Name</b>	<b>Block Code</b>	<b>Notes</b>
	Info & Ph.#	M/M	number <b>Do not use slashes, hyphens, or spaces.</b> <b>Note:</b> 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 #)