HMC HealthWorks
Smarter Healthcare Decisions™

CMS 1500 Claim Filing Instructions

Field Locator	Requirements	Field Description
1	Not Required	**Type of health insurance coverage applicable to claim** Patient's type of coverage.
1a	**Required**	**Insured's ID Number** Identification or certificate number assigned to the insured/subscriber. Please submit complete number including alpha prefix.
2	**Required**	**Patient's Name (Last, First, Middle Initial)** Patient's last name, first name, and middle initial.
3	**Required**	**Patient's Birth Date, Sex** Patient's month, day and year of birth in MM/DD/CCYY format. Patient's sex is identified by M (male) or F (female).
4	**Required**	**Insured's Name (Last Name, First Name and Middle Initial)** Subscriber's last name, first name, and middle initial. (If same as patient you may indicate "same").
5	**Required**	**Patient's Address (No, Street)** Patient's address. (If same as subscriber you may indicate "same").
6	**Required**	**Patient Relationship to Insured**

		Relationship of the patient to the subscriber. Check “other” if relationship is not self, spouse, or child of the subscriber.
7	**Required**	**Insured’s Address (No., Street)** Street and house/apartment # of the subscriber. Address may include post office box or street name and number, city, state, zip code and phone number.
8	Not Required	**Patient Status** Indicates whether the patient is single, married, employed, full or part-time student or other.
9	Required if applicable	**Other Insured’s Name (Last Name, First Name, Middle Initial)** Name of the subscriber of other coverage if the patient is covered on another policy either outside or within this Plan.
9a	Required if applicable	**Other Insured’s Policy or Group Number** Policy, certificate, or group number of an additional policy of coverage.
9b	Required if applicable	**Other Insured’s Date of Birth, Sex** Date of birth of the subscriber of an additional policy of coverage.
9c	Required for Federal Employee Program (FEP) if applicable	**Employer’s Name or School Name** Employer’s name or school name of an additional policy of coverage.
9d	Required for FEP if applicable	**Insurance Plan Name or Program Name** Company name or group name of the additional coverage.

10abc	Required if applicable	**Is Patient's Condition Related To:** Indicates if the services billed on a claim are related to or the result of employments, auto accident or other type of accident.
10d	Not applicable	**Reserved for Local Use**
11	**Required**	**Insured's Policy Group or FECA Number** Group or FECA number for the subscriber of this policy responsible for payment of this bill.
11a	Not Required	**Insured's Date of Birth, Sex** Subscriber's birth date in MM/DD/CCYY format and his/her sex identified by M (male) or F (female).
11b	Not Required	**Employer's Name or School Name** Subscriber's employer name or name of institution where enrolled.
11c	Not Required	**Insurance Plan Name or Program Name** Plan name or program name of the policy responsible for payment of this bill.
11d	**Required**	**Is There another Health Benefit Plan?** Indicates if there is other medical coverage for the patient. If so, please be sure to complete item 9a-d.
12	**Required**	**Patient's or Authorized Person's Signature** Indicates if the provider has on file a signed statement permitting the release of medical information to process the claims.

13	Required for participating providers	**Insured's or Authorized Person's Signature** Indicates if the patient (or legal guardian) or the subscriber authorizes this bill to be paid directly to the provider for the services billed on the claims.
14	Required if applicable	**Date of current: Illness (first symptom) or injury (accident) or Pregnancy (LMP)** Indicates in MM/DD/CCYY format if any of the following conditions apply to the claim. Please check appropriate box. Illness- Date of onset of the first symptom for the service billed on the claim. Injury- Date the accident occurred for the service billed on the claim. Pregnancy- Date of the patient's last menstrual period prior to the date of service.
15	Not Required	**If Patient Has Had Same or Similar Illness, Give First Date** MM/DD/CCYY format of the date the patient experienced the same or similar symptoms as the primary diagnosis billed.
16	Not Required	**Dates Patient Unable To Work In current Operation** MM/DD/CCYY format of the date the patient's work is affected by the primary diagnosis billed, from the start date to the return date.
17	Required if applicable	**Name of Referring Provider or Other Source** Name of the physician (primary or other), referring the patient to the provider submitting this claim. PCP's name required on claims for managed care members.

17a	Not Required	**Other ID#** Do not enter a provider ID number in this field.
17b	Required if applicable	**NPI# (National Provider Identifier)** NPI of the referring primary care physician (PCP). Required for managed care members who were referred by their PCPs.
18	Required if applicable	**Hospitalization Dates Related to current Services** Beginning and ending date of inpatient care if services were performed while the patient was confined in a hospital.
19	Recommended (Required for behavioral health facilities)	**Reserved For Local Use** Enter the taxonomy code for the rendering provider, immediately preceded by the qualifier ZZ. Example: ZZ207Q00000X
20	Not Applicable	Name of outside laboratory.
20	Not Applicable	Charges or portion of charges that were sent to an outside lab facility.
21	**Required**	**Diagnosis or Nature of Illness or Injury (relate items 1, 2, 3, or 4 to item 24E by line)** #1- Primary, #2- Secondary, #3- Tertiary, #4- Other ICD-10 CM diagnosis code for the illness or injury which is/are the reason(s) for the treatment shown on this bill. Use the highest level of specificity.
22	Not Required	**Medicaid Resubmission Code**
23	Required if applicable	**Prior Authorization Number**

		If prior authorization is received, indicates the authorization number assigned to the services and dates submitted on this claims.
24a	**Required**	**Date(s) of Service** MM/DD/CCYY format of the date(s) that the service(s) billed on this claim was performed.
24b	**Required**	**Place of Service (POS)** Location where services billed on this claim were performed. Valid values: National POS codes maintained by CMS.
24c	Not Required	**EMG** Not applicable.
24d	**Required**	**Procedures, Services, or Supplies** CPT or HCPCS (5-position) code describing the procedures performed, medical services rendered or the supplies furnished.
24d	Required if applicable	**Modifier** CPT/HCPCS (2-position) code that identifies special circumstances associated with the performance of the services indicated by the corresponding procedure/service/supply code. Only one modifier can be billed per procedure code.
24e	Required (for any number of diagnoses)	**Diagnosis Pointer** Indicates that the service provided was treatment for one or more of the specified "diagnosis codes" identified in Box 21. *Required even if there is only one diagnosis.* Valid Values: 1, 2, 3 or 4.
24f	**Required**	**$ Charges**

		The per line item charge(s) for the procedure(s) performed including any applicable patient copay amounts.
24g	**Required** (for any number of units)	**Days or Units** Number of identical medical services performed, as related to the corresponding procedure code. If entered the value must be a whole number, other than zero. Refer to the CPT or HCPCS coding manuals to verify if the units are per service, per minute, per 15 minutes, per 30 minutes, or per day. *Required even if there is only one (1) unit.*
24h	Not Required	**EPSDT Family Plan** Not Applicable
24i	Not Required	**ID Qualifier** Not Applicable
24j	**Required**	**Rendering Provider ID #** The NPI number for the provider who rendered the services.
25	**Required**	**Federal Tax ID Number** Nine-digit federally assigned tax ID# of the billing provider. Can be either the employer ID number (EIN) or the social security number (SSN). Please check the appropriate SSN or EIN box.
26	Required if applicable	**Patient's Account Number** Unique number assigned by the provider to identify the patient.
27	Required if patient is enrolled in Medicare	**Accept Assignment** Indicates whether the provider and the beneficiary have signed a mutual agreement authorizing Medicare carrier to pay the provider.

28	**Required**	**Total Charge** The sum of all line item charges (Box 24f 1-6) on this claim.
29	Required if applicable	**Amount Paid** The amount the provider has received from the patient or insured toward the total payment of this claim. Note that the amount entered on the claim *must* match the amount indicated on the other carrier EOB.
30	Not Required	**Balance Due** The amount of difference between the total charges (28) and the amount paid (29) to the provider for this claim.
31	**Required (including clinician's credentials)**	**Signature of Physician or Supplier *Including* Degrees or Credentials** The signature of the physician or clinician who performed the services on the claim. • If a group practice name appears in Box 33, the name of the provider who performed the services must appear in Box 31.
32	Required if applicable	**Service Facility Location Information** Name of facility other than the patient's home or physician's office, where services were performed, such as hospital or clinic.
32a	Required if applicable	**NPI#** NPI# of the service facility location.
32b	Not Required	**Other ID#** Do not enter a provider ID number in this field.
33	**Required**	**Billing Provider Info and Phone #**

		The provider's name, office street address and/or PO Box, zip code, and telephone number.
33a	**Required**	**NPI#** NPI number of the billing provider. (Place the entity Type 1 NPI of the provider who rendered the services in this field).
33b	Not Required	**Other ID#** Do not enter a provider ID number in this field.