Traditional

All claims require the complete HIC number in Block 1A of the HCFA-1500 claim form or in the appropriate field for electronic claims.

Enter the patient’s Medicare HIC exactly as it appears on the patient’s Medicare card whether Medicare is the primary or secondary payer. Enter the number without spaces and/or hyphens.

The HIC number should be nine digits, followed by a valid suffix.

Example: 1233456789A

The following are examples of valid Health Insurance Claim number suffixes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Primary claimant</td>
</tr>
<tr>
<td>B</td>
<td>Aged wife A62 (1st claimant)</td>
</tr>
<tr>
<td>B1</td>
<td>Aged husband (1st claimant)</td>
</tr>
<tr>
<td>C1 – C9</td>
<td>Child (includes disabled or student child)</td>
</tr>
<tr>
<td>D</td>
<td>Aged widow A60 (1st claimant)</td>
</tr>
<tr>
<td>D1</td>
<td>Aged widower (1st claimant)</td>
</tr>
<tr>
<td>K1 – 8</td>
<td>Prouty wife</td>
</tr>
<tr>
<td>KA – KM</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Uninsured beneficiary (not qualified for automatic HIB)</td>
</tr>
<tr>
<td>M1</td>
<td>Uninsured beneficiary (qualified for automatic HIB but requests SMI only)</td>
</tr>
<tr>
<td>T</td>
<td>Uninsured beneficiary</td>
</tr>
<tr>
<td></td>
<td>• Fully insured beneficiary elected entitlement only to HIB (usually but not always along with SMIB)</td>
</tr>
<tr>
<td></td>
<td>• Renal disease only</td>
</tr>
<tr>
<td></td>
<td>• Deemed insured HIB only</td>
</tr>
<tr>
<td>TA</td>
<td>Medicare Qualified Government Employment (MQGE) primary beneficiary</td>
</tr>
<tr>
<td>W</td>
<td>Disabled widow A50 (1st claimant)</td>
</tr>
</tbody>
</table>
Railroad Retirement

These beneficiaries have a prefix in front of the HIC number instead of a suffix after it. The number itself has either six digits or the regular nine digits.

Example:  A1233456789

Claims for Railroad Retiree’s are sent to Palmetto GBA – Railroad Medicare, PO Box 10066, Augusta, GA 30999-0001. Do not send these claims to the TrailBlazer Health Enterprises, LLC.
**Health Insurance Claim Form**

1. **Medicare** | **Medicaid** | **Champus** | **Champva** | **Group Health Plan** | **FeCa** | **Other**
   - Medicare #
   - Medicaid #
   - (Sponsor's SSN)
   - (VA File #)
   - (SSN or ID)
   - (SSN)
   - (ID)

2. **Patient's Name**
   - Last Name, First Name, Middle Initial

3. **Patient's Birth Date**
   - MM DD YY

4. **Sex**
   - M
   - F

5. **Patient's Address**
   - No., Street

6. **City**
   - State

7. **City**
   - State

8. **Patient Status**
   - Single
   - Married
   - Other

9. **Other Insured's Name**
   - Last Name, First Name, Middle Initial

10. **Other Insured's Date of Birth**
    - MM DD YY

11. **Employer's Name or School Name**

12. **Insurance Plan Name or Program Name**

13. **Is Patient's Condition Related To:**
    - Employment? (Current or Previous)
    - No

14. **Date of Current:**
    - Illness (First symptom)
    - Injury (Accident)
    - Pregnancy (LMP)

15. **Name of Referring Physician or Other Source**

16. **Reserved for Local Use**

17. **Diagnosis or Nature of Illness or Injury**.

18. **Reserved for Local Use**

19. **Date(s) of Service**
   - From
   - To

20. **Accept Assignment?**
    - Yes
    - No

21. **Reserved for Local Use**

22. **Medicaid Submission Code**

23. **Prior Authorization Number**

24. **Reserved for Local Use**

25. **Federal Tax I.D. Number**

26. **Patient's Account No.**

27. **Reserved for Local Use**

28. **Reserved for Local Use**

29. **Reserved for Local Use**

30. **Reserved for Local Use**

31. **Signature of Physician or Supplier**

32. **Reserved for Local Use**

33. **Physician's, Supplier's Billing Name, Address, Zip Code & Phone #”

**Form HCFA-1500 (12-90)**

**Form OWCP-1500**

**Form RRB-1500**

**PLEASE PRINT OR TYPE**

**(APPROVED BYAMA COUNCIL ON MEDICAL SERVICE 8/88)**
**MEDICARE PART B**

**HCFA-1500 CLAIM FORM**

*Completion Instructions*

<table>
<thead>
<tr>
<th>Item</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>Enter the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.</td>
</tr>
<tr>
<td>Item 1a*</td>
<td>Enter the patient’s Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.</td>
</tr>
<tr>
<td>Item 2*</td>
<td>Enter the patient’s last name, first name, and middle initial, if any as shown on the patient’s Medicare card.</td>
</tr>
<tr>
<td>Item 3</td>
<td>Enter the patient’s eight-digit birth date (MM/DD/CCYY) and sex.</td>
</tr>
<tr>
<td>Item 4+</td>
<td>If the patient has insurance primary to Medicare, either through the patient’s or spouse’s employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.</td>
</tr>
<tr>
<td>Item 5</td>
<td>Enter the patient’s mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.</td>
</tr>
<tr>
<td>Item 6+</td>
<td>Check the appropriate box for patient’s relationship to insured when Item 4 is completed.</td>
</tr>
<tr>
<td>Item 7+</td>
<td>Enter the insured’s address and telephone number. When the address is the same as the patient’s, enter the word SAME. Complete this item only when Items 4 and 11 are completed.</td>
</tr>
<tr>
<td>Item 8</td>
<td>Check the appropriate box for the patient’s marital status and whether employed or a student.</td>
</tr>
<tr>
<td>Item 9</td>
<td>Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in Item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.</td>
</tr>
</tbody>
</table>

**Note:** Only participating physicians and suppliers are to complete Item 9 and its subdivisions, and only when the beneficiary wishes to assign his/her benefits under a Medigap policy to the participating physician or supplier.

* R = Required: Information which **must always** be on a claim.
+ C = Conditional: Information which is **required** on a claim if certain conditions exist.
Participating physicians and suppliers must enter information required in Item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is call a mandated Medigap transfer.

**Medigap** – A Medigap policy meets the statutory definition of a “Medicare supplemental policy” contained in Section 1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation which is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the “gaps” in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as “specified disease” or “hospital indemnity” coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in Item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contract with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

**Item 9a**

Enter the policy and/or group number of the Medigap insured proceeded by MEDIGAP, MG or MGAP.

**Note:** Item 9d must be completed if you enter a policy and/or group number in Item 9a.

**Item 9b**

Enter the Medigap insured’s eight-digit birth date (MM/DD/CCYY) and sex.
Item 9c  
Leave blank if a Medigap Payer ID is entered in Item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two letter postal code, and ZIP code copied from the Medigap insured’s Medigap identification card.

Example:  
1257 Anywhere Street  
Baltimore, Maryland  21204

Is shown as “1257” Anywhere St MD 21204.”

Item 9d  
Enter the 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If you are a participating provider of service or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in Items 9, 9a, 9b and 9d must be complete and accurate. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Item 10a – 10c  
Check “YES” or “NO” to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24. Enter the state postal code. Any item checked “YES” indicates there may be other insurance primary to Medicare. Identify primary insurance information in Item 11.

Item 10d  
Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient’s Medicaid number preceded by MCD.

Item 11*  
THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured’s policy or group number and proceed to Items 11a – 11c.

Note: Enter the appropriate information in Item 11c if insurance primary to Medicare is indicated in Item 11.

* R = Required: Information which must always be on a claim.
+ C = Conditional: Information which is required on a claim if certain conditions exist.
If there is no insurance primary to Medicare, enter the word “NONE” and proceed to Item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the work “NONE” and proceed to Item 11b.

**Insurance Primary to Medicare** – Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage:
  - Working aged;
  - Disability – (Large Group Health Plan); and,
  - End Stage Renal Disease.

- No-fault and/or other liability;

- Work-related illness/injury:
  - Workers’ compensation;
  - Black Lung; and
  - Veterans benefits

**Note:** For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer’s Explanation of Benefits (EOB) notice must be forwarded along with the claim form.

### Item 11a
Enter the insured’s 8-digit birth date (MM/DD/CCYY) and sex if different from Item 3.

### Item 11b+
Enter employer’s name, if applicable. If there is a change in the insured’s insurance status, e.g., retired, enter either as six-digit (MM/DD/YY) or 8-digit retirement date (MM/DD/CCYY) preceded by the word “RETIRED”.

### Item 11c+
Enter the 9-digit PAYERID number of the primary insured. If no PAYERID number exists, then enter the complete primary payer’s program or plan name. If the primary payer’s EOB does not contain the claims processing address, record the primary payer’s claims processing address directly on the EOB.
Item 11d  Leave blank. Not required by Medicare.

Item 12*  The patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), an 8-digit date (MM/DD/CCYY), or an alphanumeric date (e.g., January 1, 2002), unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Section 3047.1 – 3047.3 Part 3 of MCM. If the patient is physically or mentally unable to sign, a representative specified in Section 3008, Part 3 of MCM may sign on the patient’s behalf. In this event, the statement’s signature line must indicate the patient’s name followed by “by” the representative’s name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient’s representative revokes this arrangement.

The patient’s signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) – When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13*  The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in Item 9 and its subdivisions. The patient or his/her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier’s office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

Item 14+  Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of current illness, injury, or pregnancy. For chiropractic services, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of the initial treatment or exacerbation of the existing condition.
Item 15  Leave blank. Not required by Medicare.

Item 16  If the patient is employed and is unable to work in current occupation, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date when patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Item 17+  Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring physician: A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician: A physician who orders non-physician services for the patient such as diagnostic laboratory test, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

The ordering/referring requirement became effective January 1, 1992, and is required by Section 1833(q) of the Social Security Act. All claims for Medicare covered services and items that are the result of a physician’s order or referral must include the ordering/referring physician’s name and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- diagnostic laboratory services;
- diagnostic radiology services;
- consultative services; and,
- durable medical equipment.

Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician’s name and UPIN. For example, a surgeon must complete Items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician’s name and assigned UPIN must appear in Items 17 and 17a.
All physicians who order or refer Medicare beneficiaries or services must obtain an UPIN even though they may never bill Medicare directly. A physician who has not been assigned an UPIN must contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for **consultative** service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in Items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

- Enter the original ordering/referring physician’s name and UPIN in Items 17 and 17a of the first claim form.
- Enter the ordering (performing) physician’s name and UPIN in Items 17 and 17a of the second claim form.

**Surrogate UPINs** – If the ordering/referring physician has not been assigned an UPIN, one of the surrogate UPINs listed below must be used in Item 17a. The surrogate UPIN used depends on the circumstance and is used only until the physician is assigned an UPIN. Enter the physician’s name in Item 17 and the surrogate UPIN in Item 17a. All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until an UPIN is assigned. The Medicare carrier will monitor claims with surrogate UPINs.

The term “physician” when used within the meaning of Section 1861(r) of the Social Security Act and used in connection with performing any function or action, refers to:

- a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he/she performs such function or action;
- a doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

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* R = Required: Information which **must always** be on a claim.
+ C = Conditional: Information which is **required** on a claim if certain conditions exist.
• a doctor of podiatric medicine for purposes of subsections (k), (m), (p)(1), and (s) and Sections 1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the state in which he/she performs them;

• a doctor of optometry, but only with respect to the provision of items or services described in Section 1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the state in which he/she performs them; or,

• a chiropractor who is licensed as such by a state (or in a state which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of Sections 1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist). For the purposes of Section 1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in Section 1862(a)(4) of the Act) are furnished.

17a+

Enter the HCFA assigned UPIN of the referring/ordering physician listed in Item 17. Enter only the seven-digit base number and the one-digit check digit.

When a claim involves multiple referring and/or ordering physicians, a separate HCFA-1500 must be used for each ordering/referring physician.

Use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited.

• Residents who are issued an UPIN in conjunction with activities outside of their residency status must use that NPI. For interns and residents without UPINs, use the eight-character surrogate UIPN RES00000;
Medicare Part B

HCFA-1500 Claim Form

Completion Instructions

- Retired physicians who were not issued an UPIN may use the surrogate RET00000;
- Physicians serving in the Department of Veterans Affairs or the US Armed Services may use VAD00000;
- Physicians serving in the Public Health or Indian Health Services may use PHS00000;
- When the ordering/referring physician has not been assigned an UPIN and does not meet the criteria for using one of the surrogate UPIN, the biller may use the surrogate UPIN “OTH00000” until an individual UPIN is assigned;
- Effective for claims with dates of service on or after July 1, 2000, the UPIN must be entered in Item 17a for hepatitis B claims.

Item 18
Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19+
Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file (See Section 2206.1, Part 3 of MCM).

Enter the drug’s name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an “unlisted procedure code” or an NOC code if one can be given within the confines of this box. Otherwise, an attachment must be submitted with the claim.

Enter all applicable modifiers when modifier –99 (multiple modifiers) is entered in Item 24d. If modifier –99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a –99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and “mod” represents all modifiers applicable to the referenced line item.

* R = Required: Information which must always be on a claim.
+ C = Conditional: Information which is required on a claim if certain conditions exist.
Enter the statement “Homebound” when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Section 2051.1, Part 3 of MCM and Section 2070.1, Part 3 of MCM respectively, for the definition of “homebound” and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, “Patient refuses to assign benefits” when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, “Testing for hearing aid” when billing services involving the testing of a hearing aid(s), which is used to obtain Intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) assumed and/or relinquished date for a global surgery claim when providers share postoperative care and/or relinquished date.

Enter the PIN (or UPIN when effective) of the physician who is performing a purchased interpretation of a diagnostic test (see MCM Part 3 Section 3060.5) for additional information.

**Item 20+**

Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the “yes” block is checked. A “yes” check indicates that an entity other than the entity billing for the service performed the diagnostic test. A “no” check indicates that “no purchased tests are included on the claim.” When “yes” is annotated, Item 32 must be completed. **When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.**
**Item 21**
Enter the patient’s diagnosis/condition. All physician specialties (i.e., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

**Item 22**
Leave blank. Not required by Medicare.

**Item 23**
Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational devise is used in a FDA-approved clinical trial.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the Home Health Agency (HHA) or hospice.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

**Item 24a**
Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date for each procedure, service, or supply. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column G.

**Item 24b**
Enter the appropriate place of service code(s) from the list provided. Identify the location, using a place of service code, for each item used or service performed.

**Note:** When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.
Places of Service

The following are the only places of service the Medicare program can accept.

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance – Land
42 Ambulance – Air or Water
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
60 Mass immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End-Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

Item 24c Medicare providers are not required to complete this item.

Item 24d* Enter the procedures, services, or supplies using the Health Care Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
Enter the specific procedure code without a narrative description. However, when reporting an “unlisted procedure code” or a NOC code, include a narrative description in Item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

Item 24e+ Enter the diagnosis code reference number as shown in Item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; either a 1, 2, 3, or 4.

If a situation arises where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses in Item 21.

Item 24f* Enter the charge for each listed service.

Item 24g* Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in Item 24g. Convert hours into minutes and enter the total minutes required for this procedure.
Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

- For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in Item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, enter the unit entry “01” indicating the nearest 50 cubic foot increment in Item 24g;
- For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10-pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, enter the unit entry “06” in Item 24g; and,
- For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or on liquid pound, respectively.

**Item 24h**  Leave blank. Not required by Medicare.

**Item 24i**  Leave blank. Not required by Medicare.

**Item 24j**  Leave blank. Not required by Medicare.

**Item 24k+**  Enter the PIN of the performing provider of service/supplier if they are a member of a group practice.

When several different providers of service or suppliers within a group are billing on the same Form HCFA-1500, show the individual PIN in the corresponding line item.

**Item 25**  Enter your provider of service or supplier federal tax ID (Employer Identification Number) or social security number. The participating provider of service or supplier federal tax ID number is required for a mandated Medigap transfer.
Item 26 Enter the patient’s account number assigned by the provider of service’s or supplier’s accounting system. This field is optional to assist you in patient identification. As a service, any account numbers entered here will be returned to you.

Item 27 Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in Item 9, and MEDIGAP payment authorization is given in Item 13, the provider of service or supplier must also be a Medicare participating provider of service or supplier and must accept assignment of Medicare benefits of all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- clinical diagnostic laboratory services;
- physician services to individuals dually entitled to Medicare and Medicaid;
- participating physician/supplier services,
- services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- ambulatory surgical center services for covered ASC procedures; and,
- home dialysis supplies and equipment paid under Method II.

Item 28 Enter total charges for the services (i.e., total of all charges in Item 24f).

Item 29 Enter the total amount the patient paid on the covered services only.

Item 30 Leave blank. Not required by Medicare.

Item 31* Enter the signature of provider of service or supplier, or his/her representative, and either a 6-digit date (MM/DD/YY) or 8-digit date (MM/DD/CCYY), or alphanumeric date (e.g., January 1, 2002) the form was signed.
Item 32+ Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient’s home or physician’s office. When the name and address of the facility where the services were furnished is the same as the biller’s name and address shown in Item 33, enter the word “SAME”. Providers of service (namely physicians) must identify the supplier’s name, address, and NPI when billing for purchased diagnostic tests. When more than one supplier is used, use a separate HCFA-1500 to bill for each supplier.

This item is completed whether the supplier personnel performs the work at the physician’s office or at another location.

If a –QB or –QU modifier is billed indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered must be entered if other than home. However, if the address shown in Item 33 is in an HPSA and is the same as where the services were rendered, enter the word “SAME”.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician’s office. If an independent laboratory is billing, enter the place where the test was performed and the UPIN.

Item 33* Enter the provider of service/supplier’s billing name, address, ZIP code, and telephone number.

Enter the PIN of the performing provider of service/supplier who is not a member of a group practice.

Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.

Enter the group PIN of the performing provider of service/supplier who is a member of a group practice.

* R = Required: Information which must always be on a claim.
+ C = Conditional: Information which is required on a claim if certain conditions exist.
# HCFA-1500 CLAIM FORM

## Completion Instructions

<table>
<thead>
<tr>
<th>DC METRO AREA:</th>
<th>DELAWARE AREA:</th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td><strong>Claims Submissions</strong></td>
<td><strong>Claims Submissions</strong></td>
</tr>
<tr>
<td>PO Box 650092</td>
<td>PO Box 650094</td>
</tr>
<tr>
<td>Dallas, TX 75266-0092</td>
<td>Dallas, TX 75266-0094</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>MARYLAND:</th>
<th>TEXAS:</th>
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<td>PO Box 660595</td>
<td>PO Box 660031</td>
</tr>
<tr>
<td>Dallas, TX 75266-0595</td>
<td>Dallas, TX 75266-0031</td>
</tr>
</tbody>
</table>

* R = Required: Information which **must always** be on a claim.
+ C = Conditional: Information which is **required** on a claim if certain conditions exist.
**Introduction**

Although we recommend electronic billing as the optimum method for filing Medicare claims, Optical Character Recognition (OCR) is a technology which permits the recognition and capture of printed data. TrailBlazer Health Enterprises, LLC uses OCR to scan and lift information printed on the HCFA-1500 claim form. OCR claims are subject to the 27-day payment floor. Only electronically filed claims have a reduced payment floor of 14 days.

Through the use of OCR, claims are entered into the processing system more rapidly than paper. In addition to the speed of entry and reduced handling time, the use of OCR reduces administrative costs and minimizes the manual intervention required to correctly process your Medicare Part B claims.

Successful optical character recognition begins with the proper submission of claims data. Printed characters must conform to the pre-programmed specifications, relative to character size, and alignment on the HCFA-1500 claim form. Only the current HCFA-1500 claim form with red dropout ink is acceptable for OCR. These characteristics cannot be copied; therefore, original forms are necessary.

**Free Testing and Assistance is Available**

In support of providers and software vendors who submit claims to Medicare Part B on the HCFA-1500 claim form, a program is being developed that will help identify properly completed claim forms. The OCR Claims Department will test paper claims for claim data placement, aberrancies, and overall ability to be scanned. Once tested, the OCR testing specialist will contact the provider or vendor to discuss the individual results and instruct him/her on any changes needed.

There are numerous software packages which are designed to computer generate the HCFA-1500 claim form. Providers who use these software packages should encourage their vendors to have their claims tested.

If you would like to have your claims tested to ensure you are filing claims accurately, please contact:

**Optical Character Recognition (OCR)**

Claim Department

(469) 372-7693
OCR User Guidelines – Paper Claims

OCR user guidelines for successful completion of the HCFA-1500 claim form via paper are as follows:

- Use typewritten characters in 10 or 12 pitch (pica);
- Use standard dot matrix or laser printer fonts. Letter quality only.
  - Do not mix fonts on the same form; and,
  - Do not use italics or script.
- Use uppercase letters for all alpha characters;
- Do not use special characters such as:
  - dollar signs;
  - decimals;
  - dashes; or,
  - other symbols or special characters.
- Do not rubber band claims together or staple;
- Enter all information on the same horizontal plane;
- Align all information within the designated field;
- Submit only six line items per claim. Do not squeeze two lines of information on one line;
- Extraneous data may not be printed, handwritten, or stamped on the form;
- Corrections may be made with white correction tape only. Do not use correction fluid. Cross-outs and write-overs cause recognition problems;
- Corrections may not be handwritten;
- Avoid old or worn print bands. Print must be dark with completely formed characters. Do not use red ink;
- Do not use hand stamps;
- Do not use highlighter;
- If you use carbon forms, please send only the original or top copy;
- Trim forms carefully only at the perforations. Narrower margins cannot be scanned;
- Noticeably thin paper cannot be used (onion skin);
- The claim should be clean, without smudges or discolorations;
- The claim form must measure exactly 8 ½" x 11";
- Claims that are not folded are easier to scan. Mail claims in large 10" x 13" envelopes;
• Do not submit a zero charge claim;
• Printers that print slashed zeros should be adjusted to print unslashed zeros;
• You may obtain HCFA-1500 claim forms through various vendors, the American Medical Association, or the US