Chapter Outline

I. Universal Insurance Claim Form
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      2. Optical Character Recognition
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         Format Rules
   B. Who Uses the Paper CMS-1500 Form
II. Documents Needed When Completing the CMS-1500 Claim Form
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IV. Preparing the Claim Form for Submission
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V. Generating Claims Electronically
VI. Claims Clearinghouses
   A. Using a Clearinghouse
   B. Direct Claims
   C. Clearinghouses versus Direct

Chapter Objectives

After completion of this chapter, the student should be able to
• Explain how the CMS-1500 “universal” insurance claim form was developed.
• Discuss the format of the form.
• List the major rules necessary for optical character recognition.
• Identify the necessary criteria for using the paper CMS-1500 form.
• Describe each of the five documents needed for completion of the CMS-1500 form.
• Apply general guidelines for completing a CMS-1500 paper form.
• Discuss the importance of proofreading claims.

Chapter Terms

abstract
ASCII (American Standard Code for Information Interchange)
assign benefits
beneficiary
claims clearinghouse
clean claims
CMS-1500 (form)
demographic information
event form
mono-spaced fonts
OCR scannable
optical character recognition (OCR)
patient ledger card
release of information
small provider
waiver


**CHAPTER OBJECTIVES**

- Explain the function of claims clearinghouses.
- Compare and contrast the use of a clearinghouse versus direct claims submission.

**OPENING SCENARIO**

Emilio Sanchez and Latisha Howard are enrolled in a health insurance course at a career school in their area. Emilio graduated from high school just last year and knew immediately what career path he wanted to pursue—health insurance administration. Latisha has worked in the healthcare field for 5 years as a nursing assistant, but she injured her back lifting a patient and had to give up her job at a long-term care facility. Because her experience lies in healthcare, she decided to stay in this discipline, but pursue a different avenue that did not involve physical exertion.

In the class in which they are enrolled, the facilitator allows students to progress at their own speed, and Emilio and Latisha found that they not only work well together, but also they work at about the same pace. Both students feel comfortable that they know the material covered in Unit I well enough to move on to Unit II and continue with their learning experience in health insurance.

After reading over the outline for Chapter 5, Emilio and Latisha agree that the idea of using a universal form for all health insurance claims makes good sense, but knowing what information to enter in each of the 33 blocks is, at this point, puzzling. They also are curious to learn how information from a patient’s health record can be adapted to this form. They reassure one another, however, that completing the CMS-1500 should become routine with practice.

**UNIVERSAL INSURANCE CLAIM FORM**

A major innovation that made the process of health insurance claims submission simpler was the development of a universal form. Before the emergence of this universal form, every insurance carrier had its own specialized type of paperwork for submitting claims. Imagine the frustration a health insurance professional must have felt trying to figure out how to complete all these different forms properly. In the mid-1970s, the Health Care Financing Administration (HCFA, pronounced “hick-fa”) created a new form for Medicare claims, called the HCFA-1500. The form was approved by the American Medical Association Council on Medical Services and was subsequently adopted by all government healthcare programs. Although the HCFA-1500 originally was developed for submitting Medicare claims, it eventually was accepted by most commercial/private insurance carriers to facilitate the standardization of the claims process. Because HCFA is now called the Center for Medicare and Medicaid Services (CMS), the name of the form has been changed to CMS-1500; however, it is basically the same document.

The National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC) have revised the CMS-1500 universal form. The original form, initiated in 1990, was referred to as CMS-1500 (12-90). The revised version is called the CMS-1500 (08-05). The new form is very similar to the original form, but there are new areas to place national provider identifier (NPI) numbers for the Referring Provider (Box 17), Service Facility Location Information (Box 32), and the Billing Provider Information (Box 33). NUCC has established the following timeline for transition to the revised version of the CMS-1500 as follows:

October 1, 2006: Health plans, clearinghouses, and other vendors should be ready to handle and accept the revised CMS-1500 Claim Form.

October 1, 2006-February 1, 2007: Providers can use either the current version (CMS-1500 [12-90]) or the revised version of the claim form (CMS-1500 [08-05]).

February 1, 2007: The CMS-1500 (12-90) will be discontinued and only the revised form should be used. All rebilled claims should use the revised form even if earlier submissions were on the discontinued form. A February 2007 transition is being used to ensure the functioning of the revised form prior to the May 23, 2007 deadline for reporting NPI numbers.
Providers should contact health plans prior to submitting claims on the revised form to ensure they are prepared to accept it. Once the new form is implemented, claims submitted on the CMS-1500 (12-90) form will be rejected.

The front and back sides of the official CMS-1500 (08-05) are shown in Fig. 5-1. Additional information regarding the revised form is available at the NUCC website listed under “Websites to Explore” at the end of this chapter.

**CMS-1500 Paper Form**

**Format of the Form**

The CMS-1500 form is an 8 1/2 x 11-inch, two-sided document. The front side is printed in OCR scannable red ink; the back side contains instructions for various government and private health programs. There are two sections to the CMS-1500; the top portion is for the patient/insured information (Blocks 1-13); the bottom portion is for the physician/supplier information (Blocks 14-33). In the later section entitled “Completing the CMS-1500,” the student learns what typically goes in each block. Keep in mind, however, that there are some minor differences from one major payer to another; these are pointed out in the individual chapters pertaining to the particular major carrier.

**Optical Character Recognition**

In most instances, when the paper CMS-1500 claim form is prepared for submission, Optical Character Recognition (OCR) formatting guidelines should be used. OCR is the recognition of printed or written text characters by a computer. This involves photo scanning of the text character by character, analysis of the scanned-in image, and translation of the character image into character codes, such as ASCII (American Standard Code for Information Interchange). ASCII is the most common format used for text files in computers and on the Internet.

In OCR processing, the scanned-in image is analyzed for light and dark areas to identify each alphabetic letter or numeric digit. When a character is recognized, it is converted into an ASCII code. Special circuit boards and computer chips designed expressly for OCR are used to speed up the recognition process. The CMS-1500 is printed in a special red ink to optimize this OCR process. When the form is scanned, everything in red “drops out,” and the computer reads the information printed within the blocks.

**Using Optical Character Recognition Format Rules**

Because many third-party carriers use OCR scanning for reading health insurance claims, the health insurance professional should complete all paper CMS-1500 forms using the specific rules for preparing a document for OCR scanning. OCR works best with originals or very clear copies and mono-spaced fonts (where each character takes up exactly the same amount of space); standard mono-spaced type fonts (such as Courier or Times New Roman) in 12-point font size and black text are recommended. No special formatting, such as bold, italics, or underline, should be used, and extreme care should be taken when keying the information. Type should be lined up so that all entries and characters fall within the spaces provided on the form.

The following are specific guidelines for preparing OCR scannable claims:

- Use all uppercase (capital) letters.
- Omit all punctuation.
- Use the MM DD YYYY format (with a space—not a dash—between each set of digits) for dates of birth.
- Use a space instead of the usual punctuation or symbols for each of the following situations:
  - dollar signs and decimal points in fee charges and ICD codes
  - dash preceding a procedure code modifier
  - parentheses around the telephone area code
  - hyphens in Social Security and employer identification numbers
- Omit titles and other designations, such as Sr., Jr., II, or III, unless they appear on the patient’s identification (ID) card.
- Use two zeros in the cents column when the charge is expressed in whole dollars.
- Do not use lift-off tape, correction tape, or whiteout.

A section of the CMS-1500 form showing the proper OCR format is shown in Fig. 5-2.

When the health insurance professional has completed the claim form, it is important that the form is thoroughly examined for errors and omissions. If you are new to the profession, it is recommended that you ask a coworker or supervisor to proofread forms before submission until you acquire the necessary proficiency in the claims process. The most important task the health insurance professional is responsible for is to obtain the maximal amount of reimbursement in the minimal amount of time that the medical record supports. Fig. 5-3 shows common CMS-1500 claim form errors and omissions.

If a claim is being resubmitted, most carriers require a new one using the original (red print) CMS-1500 form. Additional tips for submitting paper claims include the following:

- Do not include any handwritten data (other than signatures) on the forms.
- Do not staple anything to the form.
**HEALTH INSURANCE CLAIM FORM**

1. **MEDICARE**
   - Medicare #
   - Medicaid #
   - MA
   - MICH
   - CREP
   - CHAMPVA
   - CHAMPUS

2. **GROUP HEALTH PLAN (ID #)**
   - FECA
   - B/LUNG
   - BLK LUNG
   - LTD

3. **INSURED’S I.D. NUMBER**
   (For Program in Item 1)

4. **INSURED’S NAME**
   (Last Name, First Name, Middle Initial)

5. **INSURED’S ADDRESS**
   (No., Street)

6. **INSURED’S ZIP CODE**

7. **TELEPHONE**
   (Include Area Code)

8. **SEX**
   - M
   - F

9. **INSURED’S POLICY GROUP OR FECA NUMBER**

10. **INSURED’S DATE OF BIRTH**

11. **EMPLOYER’S NAME OR SCHOOL NAME**

12. **INSURANCE PLAN NAME OR PROGRAM NAME**

13. **IS THERE ANOTHER HEALTH BENEFIT PLAN?**
   - Yes
   - No

14. **INSURED’S OR AUTHORIZED PERSON’S SIGNATURE**

15. **PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE**

16. **ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

18. **DATE OF CURRENT:**
   - From
   - To

19. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

20. **OUTSIDE LAB?**

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.**

22. **MEDICAID RESUBMISSION**

23. **PRIOR AUTHORIZATION NUMBER**

24. **PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)**

25. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

26. **PATIENT’S ACCOUNT NO.**

27. **ACCEPT ASSIGNMENT?**
   - Yes
   - No

28. **TOTAL CHARGE**

29. **AMOUNT PAID**

30. **BALANCE DUE**

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

32. **SERVICE FACILITY LOCATION INFORMATION**

33. **BILLING PROVIDER INFO & Ph #**

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**Fig. 5-1** Front and back of a blank CMS-1500 (red ink) form.
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERENCES TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate, and complete. In the case of a Medicare claim, the patient’s signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker’s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient’s signature authorizes release of the information to the information plan or agency shown. In Medicare assigned and CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient’s sponsor should be provided in those items captioned in “Insured”; i.e., Items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FEA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered “incident” to a physician’s professional service, 1) they must be rendered under the physician’s immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician’s service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of nonphysicians must be included on the physician’s claim form. For CHAMPUS claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE USE AND DISCLOSURE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS, and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101,41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.


FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the agency of transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPA/; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims and appeals. I further certify that the services performed were for a Black Lung-related disorder.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the “Computer Matching and Privacy Protection Act of 1988”, permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State’s Title XIX plan and to furnish information regarding any payments claimed for providing services to individuals as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
claims that are not submitted electronically after this date, of receiving electronic transmissions: used exclusively with all carriers that have the capability of submitting claims electronically can falls into one of the two following categories, the paper CMS-1500 form can be used—but, remember, it has to be used exclusively with all carriers that have the capability of submitting claims electronically. It cannot submit some claims on paper and some electronically. It says it must submit all claims electronically. It cannot provider had no method available for the submission of claims in electronic form or if the facility submitting the claim was a small provider of services or supplies. ASCA, according to the Centers for Medicare and Medicaid Services’ website, defines a small provider or supplier as provider of services with fewer than 25 full-time equivalent employees or a physician, practitioner, facility, or supplier (other than a provider of services) with fewer than 10 full-time equivalent employees.

This provision does not prevent providers from submitting paper claims to other health plans. It also states that if a provider transmits any claim electronically, it is subject to the HIPAA Administrative Simplification requirements, regardless of size. In other words, if a provider’s office submits any claims electronically, ASCA says it must submit all claims electronically. It cannot submit some claims on paper and some electronically.

So, who uses the paper CMS-1500 form? If the provider falls into one of the two following categories, the paper CMS-1500 form can be used—but, remember, it has to be used exclusively with all carriers that have the capability of receiving electronic transmissions:

1. Providers who are not computerized and do not have the capability of submitting claims electronically can still use the paper version of the form.
2. “Small providers” who fit the previous italicized description can still use the paper version of the form.

**HIPAA Tip**

The “under 10” rule applies only to Medicare/Medicaid. If a medical facility has only one employee but is doing anything electronic, the office must be in compliance with HIPAA’s privacy rules and regulations.
Several documents are needed when completing the CMS-1500 claim form.

**Patient Information Form**

A patient information form, sometimes referred to as a patient registration form, is a document (typically one page) that patients seeking care at a healthcare facility are asked to complete for the following reasons:

1. to gather all necessary demographic information to aid the healthcare professional in providing appropriate treatment,
2. to have a record of current insurance information for claim preparation and submission, and
3. to keep health records up to date.

When the form is completed, it becomes an integral part of the patient’s health record. This information form is considered a legal document and should be updated at least once a year. It is a good idea to ask returning patients if there have been any changes since they were last in the office. A typical patient information is shown in Fig. 5-4.

**New Patient Information**

Look at this section in the example patient information form in Fig. 5-4. Note that it asks for general demographic information, such as name, address, Social Security number, and employment.

**Insurance Section**

The second section contains questions regarding the patient’s insurance. Having the patient fill out the blanks in this section is important, but it is necessary also to request and make photocopies of the front and the back of the patient’s insurance ID card. The ID card often lists additional information that patients might not routinely include on the form, such as telephone numbers for preauthorization or precertification. Also, it is common for patients to transpose or omit identifying alpha characters or numbers or both.

**Additional Insurance**

In some cases, patients may be covered under more than one insurance policy. Most patient information forms have a separate section where additional insurance is listed. Information from a secondary insurance policy should be included in this section, including the name of the policy, the policyholder’s name, and the policy numbers. It is important for the health insurance professional to confirm that the “additional insurance” is secondary. Some patients, particularly elderly patients, can become confused over the technicalities of dual insurance coverage. If the patient is uncertain which of the policies is primary and which is secondary, the health insurance professional may have to do some detective work, such as telephoning one or both of the insuring agencies, to find out.

**Insurance Authorization and Assignment**

The section on insurance authorization and assignment should be completed and signed by the patient or responsible party, in the case of a minor or mentally disabled individual. This section gives the healthcare professional the authorization to release the information necessary to complete the insurance claim form. It also “assigns benefits”—that is, it authorizes the insurance company to send the payment directly to the healthcare professional. This authorization should be updated at least once a year, unless it is a “lifetime” release of information worded specifically for Medicare claims.

**Patient Insurance Identification Card**

Every insurance company has a unique identification card that it issues to its subscribers. With Medicare, every individual (referred to as a beneficiary) has his or her own individual card. Other insurers, such as Blue Cross and Blue Shield, may issue a card that covers not only the subscriber, but also his or her spouse and any dependents included on the policy. This is referred to as a family plan.
As mentioned previously, at the same time the patient completes the information form, the health insurance professional should ask to see his or her insurance ID card and make a photocopy of it to keep in the health record.

It is important to always make sure you copy the front and the back of the ID card, if there is information on the back. On subsequent visits, ask the patient if there is any change in coverage. If so, ask for and make a copy of the

Fig. 5-4 A typical patient information form.
new card. The rationale for this procedure is to have complete and correct insurance information on file for the purpose of completing the CMS-1500 claim. It also is helpful for obtaining telephone numbers to contact for preauthorization/precertification from the carrier if certain procedures or inpatient hospitalization is required. Fig. 5-5 shows the front and back sides of a typical insurance ID card.

Patient Health Record

After the patient information form is completed, the health insurance professional should examine it to ensure that all necessary information has been entered, and that the entries are legible. The form is customarily placed in the patient’s health record near the front so that the health insurance professional has easy access to it when it is time to complete and submit a claim. Details of the patient medical record are discussed in Chapter 3. To review, a medical record is an account of a patient’s medical assessment, investigation, and course of treatment. It is a source of information and a vital component in quality patient care. A complete medical record should:

- outline the reason for the patient’s visit to the healthcare professional,
- document the healthcare professional’s findings,
- include a detailed discussion of the recommended treatment,
- provide information to any referring physician or other healthcare provider,
- serve as a teaching or research tool (or both), and
- provide a means for assessing the quality of care by the practitioner or other healthcare provider.

The clinical chart note illustrated in Fig. 5-6 is a typical example taken from a patient’s health record.

Imagine This!

Tammy Butler visited Dr. Harold Norton, her family care provider, on February 10 for her yearly wellness examination plus routine diagnostics. Dr. Norton’s health insurance professional submitted the claim the day after the visit. A month later, Tammy received an EOB from her health insurer indicating that the services were not covered under her policy. Assuming that her policy did not cover wellness examinations, Tammy forgot about it. During Christmas vacation of that same year, Tammy again visited Dr. Norton for a case of sinusitis. The claim was denied again by her insurer. Puzzled that a second claim had been denied, Tammy contacted Dr. Norton’s office and, after some extensive research, learned that they had filed her claims under an old ID number from a previous employer. The problem now was that it was now January of a new year—past the deadline for filing claims for the previous year. The health insurance professional at Dr. Norton’s office informed Tammy that she was responsible for the charges.

Stop and Think

In the scenario in Imagine This!, do you agree with Dr. Norton’s health insurance professional that Tammy is responsible for the charges on the two visits in question? What should the health insurance professional have done to prevent this?

Fig. 5-5 Insurance ID card.
ENCOUNTER FORM

We have discussed three of the items necessary for completing the CMS-1500 form. Now we look at a document used by most medical practices, which is often referred to as the *encounter form*. This multipurpose billing form is known by many names (e.g., superbill, routing form, patient service slip). The encounter form can be customized to medical specialties and preprinted with common diagnoses and procedures for that particular specialty. Fig. 5-7 shows an example of an encounter form.

Typically, this form is clipped to the front of the patient’s medical record before the patient is seen in the clinical area. Note the variety of information included on the form shown in Fig. 5-7:

- demographic,
- accounting,
- professional services rendered,
- CPT and ICD-9 codes,
- professional fees, and
- return appointment information

It is important that the sections dealing with professional services, diagnostic, and procedure codes be updated annually so that revised codes are changed, new codes are added, and old codes are deleted.

The following is a typical routine in many medical offices. Each morning, the medical records clerk (or whichever member of the healthcare team is in charge of this task) prepares the health records for the patients who are to be seen that day. An encounter form is attached to the front of each record, and any areas on the form regarding the date of service, patient demographics, and accounting information is filled out. (If computerized patient accounting software is used, this is printed automatically on the form.) Each encounter form has a number (usually at the top), which serves as an identifier for that particular patient visit.

As each patient is seen in the clinical area, the healthcare provider indicates on the form what services or procedures were performed along with the corresponding fees. The provider signs the encounter form and indicates if and when the patient needs to return or have any follow-up tests. It is important that the encounter form is checked for accuracy, after which the medical receptionist totals the day’s charges, enters any payment received, and calculates the balance due. The patient receives a copy of the completed encounter form, and a copy is retained in the medical office for accounting purposes and future reference in case any question comes up regarding that particular visit. Many offices file these forms by number within files that are separated into months and days. Medical offices are subject to accounting and insurance audits. The original encounter form can be requested by auditors to verify services rendered on any patient or on any date of service. A few insurance companies still accept the original encounter form for claim payment; in some cases, an insurer asks that a copy of the encounter form be included with the CMS-1500 claim form.
**Tri-State Medical Group**

**Insurance ID# - Primary**

**Patient Name**

**Account No.**

**Age 40-64**

**Age 12-17**

**Age 1-4**

**Immunizations & Injections**

**X-ray**

**Laboratory Procedures**

**Office Consultation**

**Laboratory Procedures**

**Radiology Procedures**

**Office Procedure / Minor Surgery**

**Billable Copy**

**Provider's Signature Date**

**Fig. 5-7** Sample encounter form.
Patient Ledger Card

In offices that do not use computerized patient accounting software, patient charges and payments are kept track of on a patient ledger card (Fig. 5-8). A ledger card is an accounting form on which professional service descriptions, charges, payments, adjustments, and current balance are posted chronologically. Although many medical professional offices are becoming computerized, there are still some offices that are not, so to become a well-rounded healthcare professional, you must be familiar with manual accounting methods.

A patient ledger card is prepared for each new patient. In some medical offices, particularly family practice facilities, one ledger card is set up for the head of household, and all dependent family members are included on it. This makes sense because it not only saves time and space in the ledger file, but also minor children usually are not responsible for their own bills, and statements are normally not addressed directly to them. Be cautious, however, in the case of divorced parents because it is important that the parent who is financially responsible for the child is billed. More information is given on the maintenance of the patient ledger card as we proceed through the chapters on third-party payers and process insurance claims and reimbursements.

COMPLETING THE CMS-1500 PAPER FORM

Before filling in any of the blocks, type the name and address of the insurance carrier to whom the form will be mailed. This information should appear in the upper right hand corner of the form as illustrated in Fig. 5-9.

The following instructions for completing the CMS-1500 are relatively nonspecific. For the most part, they do not include details specific to any one major carrier, such as Medicare or Medicaid. More detailed guidelines applicable to each of the major carriers are presented in later chapters under the particular carrier’s name. In these generic guidelines, we assume that the patient is covered by a private (commercial) insurance policy and has no secondary insurance coverage.

Patient/Insured Section

Information required in many of the blocks varies from claim to claim and from one insurance carrier to another. Blocks 9 through 9d are examples of this. For a patient who has no secondary coverage, blocks 9 through 9d are left blank. More detailed information is given as to how these blocks should be completed as each major carrier is discussed later in the text.

Block 1—Indicate the type of health insurance coverage applicable to the claim by checking the appropriate box. Usually, only one box is checked except when the claim involves dual coverage, in which case more than one box is checked.

Block 1a—Enter the patient’s health insurance claim number exactly as it appears on his or her ID card including any alpha characters.

Block 2—Enter the patient’s last name, first name, and middle initial (if any). Do not use shortened names or nicknames. (Remember to use upper case letters and no punctuation.)

Block 3—Enter the patient’s 8-digit birth date, using the MM DD YYYY format, and check the appropriate box for sex. It is important to use this exact formatting style (the 4-digit year) for a birth date so that it is clear when the patient was born. Entering a birth date of 05 10 03 could represent a centenarian or a young child.

Block 4—Enter the policyholder’s (subscriber’s) name here exactly as it is listed on the insurance card. If the patient and the policyholder are one and the same, enter the word “SAME.”

Note: On Medicare claims, the patient (referred to as the beneficiary) and the policyholder are the same. Sometimes there is insurance primary to Medicare, through the patient’s or spouse’s employment or some other source. If this is the case, list the insured’s name here. If Medicare is primary, leave blank. (Instructions on how to fill out the CMS-1500 claim form for Medicare secondary claims are discussed in Chapter 9.)
**STATEMENT**

Tri-State Medical Group  
400 North 4th Street  
Anytown, Iowa 50622  
Phone: 319-555-5734  
Fax: 319-555-5758

Mrs. Samantha Taylor  
6345 Elm  
Ames, Iowa 50010

<table>
<thead>
<tr>
<th>DATE</th>
<th>PROFESSIONAL SERVICE DESCRIPTION</th>
<th>CHARGE</th>
<th>CREDITS PAYMENTS</th>
<th>CREDITS ADJUSTMENTS</th>
<th>CURRENT BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-15-xx</td>
<td>Init OV, D hx/exam, LC decision making.</td>
<td>95 00</td>
<td></td>
<td></td>
<td>95 00</td>
</tr>
<tr>
<td>12-15-xx</td>
<td>EKG &amp; interpret &amp; report.</td>
<td>55 00</td>
<td></td>
<td></td>
<td>150 00</td>
</tr>
</tbody>
</table>

Due and payable within 10 days. Pay last amount in balance column

Key: PF: Problem-focused  
EPF: Expanded problem-focused  
D: Detailed  
C: Comprehensive  
SF: Straightforward  
LC: Low complexity  
MC: Moderate complexity  
HC: High complexity  
CON: Consultation  
CPX: Complete phys exam  
E: Emergency  
HCN: House call (night)  
HCD: House call (day)  
HV: Hospital visit  
OV: Office visit

Fig. 5-8 Sample patient ledger card (Modified from Fordney MT: Insurance handbook for the medical office, ed 9, St Louis, 2006, Saunders.)
## HEALTH INSURANCE CLAIM FORM

<table>
<thead>
<tr>
<th></th>
<th>MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE CHAMPUS</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN</th>
<th>OTHER</th>
<th>PICA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare</td>
<td>Medicaid</td>
<td>TRICARE CHAMPUS</td>
<td>CHAMPVA</td>
<td>Group Health Plan</td>
<td>Other</td>
<td>PICA</td>
</tr>
<tr>
<td>2.</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Patient's Birth Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
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<td></td>
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</tr>
<tr>
<td>8.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
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<td></td>
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<tr>
<td>10.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>12.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>13.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Fig. 5-9 How and where name and address of carrier should appear on the CMS-1500 form.*

---

**Block 5**—Enter the patient’s mailing address (city, state, and Zip Code) and telephone number as the form indicates. Remember, do not separate the telephone number groups with dashes.

**Block 6**—Check the applicable box for the patient’s relationship to the insured when Block 4 is completed. (Do not use the box for “other.”)

**Block 7**—Enter the policyholder’s address and telephone number. If the address is the same as the patient’s, enter “SAME.” (Usually, this item is completed only when Blocks 4 and 11 are completed.)

**Block 8**—Check the appropriate box for the patient’s marital status and whether employed or a student. Checking the “married” or “student” boxes is not mandatory for all carriers.

**Blocks 9-9d**—Rather than try to explain what information to enter here for various third-party carriers, these blocks are left blank for this generic run-through, and they are addressed individually in later chapters.

**Blocks 10-10c**—This is a crucial area of the form. You must check “yes” or “no” to indicate whether the services or procedures listed in Block 24 are the result of an accident or illness resulting from employment, an auto accident, or other accident. If auto accident is checked, enter the 2-letter code for the state in which the accident occurred. An item checked “yes” indicates that there may be another insurance carrier that is primary, such as workers’ compensation or an auto insurance carrier.

**Block 10d**—This block is used for Medicaid claims. If the patient is a Medicaid recipient, enter the patient’s Medicaid ID number preceded by the letters “MCD.” Otherwise, leave blank. (Verify this with your state Medicaid office.)

**Block 11**—The completion of this item, similar to Blocks 9 through 9d, depends on the guidelines of the carrier to whom the claim is being sent or whether or not the patient is covered under another insurance policy. If there is a second health insurance policy, go back and complete Blocks 9 through 9d. In our generic case, the “patient” is covered by a private insurance company with no secondary coverage. In this case, Blocks 11 through 11c are left blank.

On Medicare claims, completion of this item acknowledges that the physician/supplier has made a good faith effort to determine whether Medicare is the primary or secondary carrier. More detailed information is given in the sections of the text that deal with the various major carriers.

**Block 11a**—Enter the insured’s 8-digit birth date and sex, if different from Block 3.

**Block 11b**—If this is an employer-sponsored group insurance, enter the employer’s name. For Medicare claims, if the beneficiary is retired, enter the 8-digit retirement date preceded by the word “RETIRED.”

**Block 11c**—For most claims, this item is left blank. For Medicare claims, enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, enter the program or plan name of the primary payer.

**Block 11d**—Check “yes” or “no,” whichever is applicable. Leave blank on Medicare claims.

**Block 12**—The patient (or his or her authorized representative) must sign and enter the date in this block. If there is a current release of information retained in the patient’s health record, a physical signature is not required, and the words “SIGNATURE ON FILE” or the letters “SOF” can be entered. (Remember, for a release of information to be valid, it should not be more than one year old. On Medicare claims, a properly worded “lifetime” release of information is acceptable.) An example of a HIPAA-compliant release of information is shown in Fig. 5-10. A Medicare-approved lifetime release of information is shown in Chapter 9.

**Block 13**—A signature here tells the insurance carrier that the patient (or insured) authorizes them to assign benefits (send reimbursement check directly to the healthcare provider). If a separate signed authorization to assign benefits exists elsewhere (it is often included on a patient information form), the letters “SOF” can be entered. In certain instances, a signature here is unnecessary, but there are some exceptions, as in the case of Medicaid and Medigap. (This information is discussed in more detail in later chapters.)
PHYSICIAN/SUPPLIER SECTION

We now turn our attention to the part of the CMS-1500 form that contains information the health insurance professional must abstract, from the health record or the encounter form or both. Learning how to abstract, or pull out, information from the health record that is necessary for completing the CMS-1500 claim form takes some level of expertise, which the novice health insurance profes-

<table>
<thead>
<tr>
<th>What Did You Learn?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the rationale for using the MM DD YYYY date format?</td>
</tr>
<tr>
<td>2. When is it necessary to complete Blocks 9 through 9d?</td>
</tr>
<tr>
<td>3. Why is it important to check “yes” or “no” in all three boxes in Blocks 10 through 10c?</td>
</tr>
</tbody>
</table>

Physician/Supplier Section

We now turn our attention to the part of the CMS-1500 form that contains information the health insurance professional must abstract, from the health record or the encounter form or both. Learning how to abstract, or pull out, information from the health record that is necessary for completing the CMS-1500 claim form takes some level of expertise, which the novice health insurance profes-

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant Name: ___________________________  ID Number: ___________________________

Person(s) authorized to provide information:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Person(s) authorized to receive information:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Description of information to be used or disclosed:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

(Facility Name) will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

This authorization will expire ___________________________. (Indicate date, or an event relating to you personally or to the purpose of the authorization).

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying (Facility Name) in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by (Facility Name). I have the right to seek assurances from the above-named person(s) authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

Signature of Participant ___________________________  Date ___________________________

Printed Name of Participant’s Personal Representative ___________________________  Relationship to the Participant ___________________________

Fig. 5-10  Form for authorization for release of information.
The new CMS-1500 form (08-05) accommodates the National Provider Identifier (NPI) numbers that all health care providers or organizations defined as “covered entities” under HIPAA must obtain. This unique 10-digit numeric identifier is considered permanent and, once assigned, will be assigned for life. The NPI will replace all other provider identifiers previously by health care providers, e.g. UPIN, Medicare/Medicaid numbers, etc.

When completing the CMS-1500 form, date fields (other than date of birth), should be one or the other format, 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY). Intermixing the two formats on the claim is not allowed. The date of birth must be in the 8-digit format.

**Block 14**—Enter the date of the first symptom of the current illness, injury, or pregnancy in this block (if one is documented in the health record) or the date of the last menstrual cycle if the claim is related to a pregnancy. Use caution here because an incorrect date could indicate a preexisting condition, and the claim could be rejected.

*Example:* If a patient was treated for a back injury before the effective date of his or her existing healthcare policy, this policy might not cover charges stemming from this same back injury.

**Block 15**—Enter the date the patient was first treated for this condition. (Leave blank for Medicare claims).

**Block 16**—Enter the date (or date range) that the patient was unable to work in his or her current occupation if it is a workers’ compensation claim. Completion of this block is not required for most other carriers.

**Block 17**—Enter the name of the referring or ordering physician, if applicable. For laboratory and x-ray claims, enter the name of the physician who ordered the diagnostic services.

For example, if Dr. Madigan orders an electrocardiogram, which is performed by a medical assistant but interpreted by Dr. Madigan, his name is entered into Block 17. Completion of this block also is required if billing for a consultation.

**Blocks 17a and 17b**—An entry in Block 17a and/or 17b is required when a listed service on the form was ordered or referred by a physician. The provider’s unique provider identification number (UPIN) can be used until May 22, 2007. The UPIN should appear in Block 17a. Effective May 23, 2007, the UPIN in 17a is not to be reported. Instead, the NPI must be reported in 17b when a service was ordered or referred by a physician.

*Note:* If a claim involves multiple referring and/or ordering physicians, a separate form should be used for each ordering/referring physician.

**Block 18**—If the claim is related to a hospital stay, enter the dates of hospital admission and discharge. If the patient has not yet been discharged, leave the “to” box blank.

**Block 19**—Enter either a 6-digit or an 8-digit date the patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when an independent physical or occupational therapist submits claims or a physician providing routine foot care submits claims.

**Block 20**—Leave this block blank if no laboratory or diagnostic tests were performed. If any diagnostics are listed in Block 24, and these services were performed in the provider’s facility, check “No” or leave blank. If any diagnostic tests shown on the claim were performed by an outside laboratory and billed to the provider, check “Yes,” then enter the total amount of the charges in the space provided.

**Block 21**—Enter the patient’s diagnosis using ICD-9-CM code number, listing the primary diagnosis first. There is space for up to four codes (listed in priority order) in Block 21.

**Block 22**—This block is used only for Medicaid replacement claims.

**Block 23**—This block is conditionally required. Consult the specific guidelines for the payer to whom the claim is being submitted.

**Block 24a**—Submit each date of service on a separate line. Enter the month, day, and year (in the MM DD YYYY format) 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 24G. *Note:* Only one procedure may be billed on each line. If there are more than six procedures, a second claim form will need to be used.

**Block 24b**—Enter the applicable place of service code (Table 5-1).

**Block 24c**—This block is conditionally required. Enter an “X” or an “E” as appropriate for services performed as a result of a medical emergency. Leave blank for Medicare claims.

**Block 24d**—Enter the procedure, service, or supply code using appropriate 5-digit CPT or HCPCS procedure code. Enter the 2-digit modifier when applicable. If using an unlisted procedure code (codes ending in “…99”), a complete description of the procedure must be provided as a separate attachment.

**Block 24e**—Link the procedure/service code back to the diagnosis code in Block 21 by indicating the applicable number of the diagnosis code (1, 2, 3, or 4).

**Block 24f**—Enter the amount charged for each listed procedure, supply, or service.

**Block 24g**—Enter the number of days or units. If only one service is performed, enter the number 1. Do not leave blank.

**Block 24h**—This is required only on certain Medicaid claims. EPSDT is an acronym for Medicaid’s Early and Periodic Screening Diagnosis and Treatment Program. If this is applicable, enter the appropriate code. The annual EPSDT report (*Form CMS-416*) (*PDF-47K*) provides
TABLE 5-1 Place-of-Service Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency department—hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory surgical center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing center</td>
</tr>
<tr>
<td>26</td>
<td>Military treatment facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial care facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance—land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance—air or water</td>
</tr>
<tr>
<td>50</td>
<td>Federally qualified health center</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient psychiatric facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric facility partial hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community mental health center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate care facility/mentally retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential substance abuse treatment facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric residential treatment center</td>
</tr>
<tr>
<td>60</td>
<td>Mass immunization center</td>
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<tr>
<td>61</td>
<td>Comprehensive inpatient rehabilitation facility</td>
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<tr>
<td>62</td>
<td>Comprehensive outpatient rehabilitation facility</td>
</tr>
<tr>
<td>65</td>
<td>End stage renal disease treatment facility</td>
</tr>
<tr>
<td>71</td>
<td>State or local public health clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent laboratory</td>
</tr>
<tr>
<td>99</td>
<td>Other unlisted facility</td>
</tr>
</tbody>
</table>

Basic information on participation in the Medicaid child health program.

Block 24i—Enter the ID qualifier 1C in the shaded portion for Medicare claims. Contact the third party payer for ID qualifiers for non-Medicare claims.

Block 24j—Prior to May 23, 2007, enter the rendering provider’s PIN in the shaded portion. After May 23, 2007, do not use the shaded portion. Instead, enter the rendering provider’s NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor into the shaded position.

Block 25—Enter the 9-digit federal tax identification number assigned to that provider (or group), and check the appropriate box in this field. In the case of an unincorporated practice, enter the provider’s Social Security number.

Block 26—This block is conditionally required. Enter the patient’s account number as assigned by the provider’s accounting system.

Block 27—Check the appropriate block to indicate whether the provider accepts assignment of benefits. If the supplier is a participating provider, assignment must be accepted for all covered charges. For nonparticipating providers, this can be left blank. For Medicare and Medicaid claims, check “yes.”

Block 28—Enter the total charges for services listed in column 24f.

Block 29—Enter the total amount, if any, that the patient has paid. Leave blank if no payment has been made.

Block 30—This block is conditionally required. Enter the balance owing (Block 28 minus Block 29).

Block 31—Enter the signature of the provider, or his or her representative and his or her initials, and the date the form was signed. The signature may be typed, stamped, or handwritten; however, no part of the signature should fall outside of the block.

Block 32—Enter the word “SAME” in this block, if the individual carrier’s guidelines allow it. Medicare requires the name, address, and zip code of the facility regardless of where services were performed and does not allow “SAME.”

Block 32a—Enter the NPI of the service facility in Block 32.

Block 32b—Enter the appropriate ID qualifier followed by one blank space and then the PIN of the service facility. After May 23, 2007, 32b is not to be reported.

Block 33—Enter the provider’s billing name, address, zip code, and telephone number.

Block 33a—Effective May 23, 2007, the NPI of the billing provider or group must be reported here.

Block 33b—Enter the appropriate ID qualifier followed by one blank space and then the PIN of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported. Enter the group UPIN, including the two-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.

The physician/supplier portion of the CMS-1500 form is the most challenging part. There is so much to learn, and the fact that all major payers’ guidelines are slightly different complicates the process. Be patient, however, because you will not be expected at this point to know everything.

Refer to “Websites to Explore” at the end of this chapter for more detailed instructors for completing the new CMS-1500 (08-05) claim form.
PREPARING THE CLAIM FORM FOR SUBMISSION

Proofreading

After the form has been completed according to the applicable payer guidelines, it should be meticulously proofread for accuracy. The goal is always to submit clean claims—claims that can be processed for payment quickly without being returned. Returned or rejected claims delay the payment process and cost the practice and the patient money. On average, nearly one quarter of the claims submitted by medical practices to insurers are rejected because they contain some type of error. One national professional association estimates that resubmitting a paper claim could cost a medical practice between $24 and $41.67.

A claim that is rejected for missing or invalid information must be corrected and resubmitted by the provider. Common examples of claim rejections include the following:

- Incomplete/invalid patient diagnosis code
- Diagnosis code that does not justify the procedure code
- Missing or improper modifiers
- Omitted or inaccurately entered the referring/ordering/supervising provider’s name or NPI
- Performing physician/supplier is a member of a group practice; however, you did not complete or enter accurately their carrier-assigned PIN
- Insured’s subscriber or group number missing or incorrect
- Charges not itemized
- Provider signature missing

Claim Attachments

Under certain circumstances, it may be necessary to include certain supporting documentation with a claim, as in the case where an unlisted procedure code (a code ending in “99”) is used or to justify certain procedures or charges or both. Attachments also might include laboratory reports, physician notes, and other documents, which further explain the medical appropriateness for the claim. When it is necessary to include an attachment with the claim, a complete description of the procedure must be provided as a separate document and included with the completed CMS-1500 claim form. Every carrier has specific guidelines for how to handle attachments. A carrier’s guidelines may state that “all attachments must be at least 3-5 inches in size and clearly readable.” Under most circumstances for paper claims, the attachment is paper-clipped behind each claim form when submitted. (Most carriers prefer that attachments not be stapled to the claim form.)

One last thing you must remember to do before mailing the claim is to make a copy of the completed form for your files. Some carriers require making and keeping copies of paper claims for a certain length of time (e.g., 5 years). Consult your carrier’s guidelines to find out how long you must retain copies of paper claims.

Tracking Claims

Many practices use some sort of claims follow-up system so that claims can be tracked and delinquent claims resolved before it is too late to resubmit (as in the case of a lost claim). An example of a claims follow-up system is an insurance log or insurance register. The insurance log or register should include various entries, such as the patient’s name, insurance company’s name, date claim filed, status of the claim (e.g., paid, pending, denied), date of explanation of benefits (EOB) or payment receipt, and resubmitted date. A claims follow-up system can be set up manually or electronically. It is a helpful tool for the health insurance professional and the provider because it ultimately leads to an increase in payments to the practice. Insurance claims can be overlooked if a tracking system is not in place, which can lead to lost revenue. Fig. 5-11 shows an example of an insurance log.

What Did You Learn?

1. When should a provider’s name appear in Block 17?
2. If a provider’s name appears in Block 17, what should be entered in Block 17a?
3. When is it acceptable to include “no charge” services on the CMS-1500?
4. How should Block 33 be completed if the provider is a member of a physician’s group?

1. What crucial function should be performed after the claim has been completed?
2. List four common reasons that claims are rejected.
3. Under what circumstances should supporting documents accompany a claim?

Generating Claims Electronically

Many practices submit their claims electronically because of the time and money savings that result. Experts tell practitioners that processing insurance claims electronically (1) improves cash flow, (2) reduces the expense of
claims processing, and (3) streamlines internal processes, allowing them to focus more on patient care. On average, a paper insurance claim typically takes 30 to 45 days for reimbursement, whereas the average payment time for electronic claims is approximately 10 to 14 days. This reduction in insurance reimbursement time results in a significant increase in cash available for other practice expenses. As with everything, however, there is a tradeoff because often the expense of setting up for an electronic process is not taken into account. First, the office has to purchase adequate equipment—computers, printers, and software programs. Additionally, everyone involved in the claim process must become computer literate. Depending on the size and needs of the practice, computer hardware and software can cost from $10,000 to $250,000. Also, an intensive training program may be needed to teach staff how to use the equipment and become adept at operating the software.

There are basically two ways to submit claims electronically: through an electronic claims clearinghouse or directly to an insurance carrier. Many large practices can be set up to support both methods. Whether a practice chooses to use a clearinghouse or to submit claims directly to the carrier, it usually must go through an enrollment process before submitting electronic claims. The enrollment process is required so that the company the practice has hired to set up information about the practice on their computer system. Most government and many commercial carriers require such an enrollment. Some also require that the practice sign a contract with them. The enrollment process typically takes 6 to 7 weeks to complete. The largest obstacle in getting set up for electronic claims processing is the time that it takes for approval from state, federal, and, in some cases, commercial/health maintenance organization carriers.

## CLAIMS CLEARINGHOUSES

A claims clearinghouse is a company that receives claims from healthcare providers and specializes in consolidating the claims so that they can send one transmission to each third-party payer containing batches of claims. A clearinghouse typically is an independent, centralized service available to healthcare providers for the purpose of simplifying medical insurance claims submission for multiple carriers. HIPAA defines a healthcare clearinghouse as “a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.” The clearinghouse acts as a simple point of entry for paper and electronic claims from providers. Clearinghouse personnel edit the claims for validity and accuracy before routing the edited claim on to the proper third-party carrier for payment. A medical practice can send all completed claims to one central location, rather than to multiple payers. If the clearinghouse finds errors on the claim that would cause the claim to be rejected or denied, it sends the claim back to the provider for correction and resubmission.
Clearinghouses also are capable of translating data from one format to another (e.g., electronic to paper or vice versa). Many private clearinghouses are available to healthcare providers and payers that facilitate electronic and paper claims processing. Payers also can act as clearinghouses for claims of other payers.

Most clearinghouses have the ability to meet the requirements of each insurance company using their specific computer formats. They can submit electronic claims to any insurance company in a format that exactly matches that of the insurance company's computers. This clearinghouse task is essential for electronic claims because it is usually too complex and costly for independent billing services to perform on each claim. Clearinghouse services are not free, however. Charges for paper claims vary from 25 to 75 cents each, but some providers feel the advantages outweigh the disadvantages. Electronically submitted claims are less costly (some cost only 5 cents each), and many clearinghouses do not charge for claims submitted in certain standard electronic formats.

**Using a Clearinghouse**

Here is how using a clearinghouse typically works. The medical practice subscribes to a clearinghouse. After this process is completed, the health insurance professional enters the practice's billing information in a preformatted template, and a file is created from this template that contains that practice's specific claim information. This file is transmitted through the modem to the clearinghouse using the clearinghouse's specific built-in functionality.

As the clearinghouse receives claims from the medical practice, they are checked for completeness and accuracy. If an error has been made, the practice is notified that there is a problem with a claim. Ideally, the claim information is quickly corrected, and the claim is resubmitted to the clearinghouse. This validation process normally takes just minutes, eliminating the costly delays associated with submitting “dirty” claims directly to the insurer. When submitted and validated for accuracy, claims are forwarded electronically (in most cases overnight) to the specific insurance carriers for reimbursement.

**Direct Claims**

Submitting electronic claims directly to an insurance carrier is a little more complicated. As explained previously, you first must enroll with the carrier. Most government carriers and many commercial carriers require that you enroll with them before submitting claims electronically to them. You also need some additional software from each insurance carrier to whom you wish to submit claims. Many carriers have their own software or can refer the health insurance professional to someone who supports direct transmissions in the area.

The most common direct claims submission method is done by creating a “print image” file of the claim and using the applicable direct claims software to send the claim to the proper insurance carrier. Printing claims to a file is as easy as printing claims to paper. The first step is to set up a printer properly that has the capability to designate “print to file.” After completing the printer setup and entering the billing information, claims can be printed to the carrier transmission file. The health insurance professional would select an option such as “print insurance claims” and select which claims to send to a particular insurance carrier. When prompted to select a printer to print claims, you simply select the printer that has been set up to print to file. A prompt screen appears requesting that you enter a filename. Enter the filename that was given to you by the direct claims software product. Then using the direct claims software, transmit the file to the carrier. Some carriers may “edit” claims; the health insurance professional needs to work with that particular insurance carrier to determine how to identify and resubmit claims that contain errors.

**Clearinghouses Versus Direct**

When deciding whether to send claims electronically through a clearinghouse or direct to the carrier, there are several things to consider. Carrier direct is usually less expensive if the medical practice submits most claims to just one carrier. When multiple carriers are used, however, a clearinghouse is generally less expensive. With a clearinghouse, the health insurance professional needs to dial into only one location. If the decision is made to go direct, there will be multiple dialups. When using a clearinghouse, all claims can be submitted in one transmission, and the convenience of sending all claims to one location should not be underestimated. Submitting claims to multiple insurance carriers requires members of the health insurance team to become experts in each of the claims submission software applications used. Because each one is unique, the health insurance professional must be adequately trained and available to submit all variety of claims. Clearinghouses typically generate a separate confirmation report for each carrier where claims are submitted directly.

Insofar as which method of electronic claims submission is better, if a medical practice submits insurance claims to only multiple carriers and has someone who is well trained technically to handle the task of electronic claims submission, an electronic claims clearinghouse might be the better choice. If claims are sent primarily to one carrier, the practice should consider using direct submission to that carrier. Whichever method is selected, it is a proven fact that claims are processed much faster and reimbursement time is shortened using electronic claims submission.
SUMMARY CHECK POINTS

In the mid-1970s, HCFA created a form for Medicare claims, which was approved by the American Medical Association Council on Medical Services. All government healthcare programs and most commercial/private carriers subsequently adopted this form, now referred to as the CMS-1500, to standardize the claims process.

The CMS-1500 is an 8\(\frac{1}{2}\) × 11–inch, two-sided form printed in OCR scannable red ink. The top section of the form is for patient/insured information; the bottom section is for provider/supplied data.

For the CMS-1500 form to be OCR “readable,” certain rules must be followed. Some of the more important ones are

- use all uppercase letters,
- omit all punctuation, and
- use the MM DD YYYY format (with a space—not a dash—between each set of digits) for dates of birth.

HIPAA mandates that all providers must submit claims electronically unless the provider falls into either of the following categories:

- The healthcare provider has no method available for submitting claims in electronic format.
- The "small provider" criteria are met, which are defined as a provider of services with fewer than 25 full-time equivalent employees or a physician, practitioner, facility or supplier.

In either of these cases, the Secretary may grant a waiver from the mandatory electronic submission rule.

The five documents needed for completion of the CMS-1500 include the following:

- The patient information form, which supplies demographic and insurance information and provides the necessary signed release of information.
- The patient’s insurance ID card, which contains current subscriber numbers and other information necessary for preauthorization of certain procedures and inpatient hospitalization.
- The patient’s health record, which contains detailed documentation of the reason for the patient’s visit, the physician’s findings, and a discussion of the recommended treatment.
- The encounter form, which includes the professional services rendered and corresponding CPT and ICD-9 codes.
- The patient ledger card, which documents the fees charged for the services listed on the claim form.

The primary objective in submitting claims is to submit “clean” claims. For this reason, thorough proofreading of each claim form is crucial to prevent claim rejection or denial.

A claims clearinghouse is a company that receives multiple claims from healthcare providers, edits each for validity and accuracy, and routes the edited claims on to the proper carrier for payment.

Studies have shown that a clearinghouse is the best method of submitting electronic claims if the provider submits claims to multiple carriers. Direct claim submission is the method of choice if most claims are being sent to a single carrier.
CLOSING SCENARIO

Studying the information in Chapter 5 one topic at a time and reviewing each main point proved helpful to Emilio and Latisha in comprehending the new material. The chapter contained a lot of information that could have proved difficult had they not adopted a structured method for studying. At the beginning of the chapter, the CMS-1500 form presented a challenging picture, as did the concept of OCR. The students worked through the “generic” guidelines many times, however, until they felt they understood them thoroughly. To get a better grasp on the OCR rules, they practiced lining up the forms and keying information into the blocks using the all caps, no punctuation OCR format.

Emilio preferred to learn how to generate claims using a computer; however, he realized it was important to understand what information should appear in each of the 33 blocks of the form, why that particular piece of datum needed to be there, and how it was derived. Emilio and Latisha agree now that the best way to understand the intricacies of the CMS-1500 form is to abstract information from the five documents explained in the chapter and generate a paper claim. After completing this chapter, Latisha believes she is now ready to begin completing paper forms at the clinic where she volunteers.

WEBSITES TO EXPLORE

• For students who are interested in learning more about OCR technology, log on to the following website, key “OCR Technology” into the search block, and peruse articles of interest.
  http://www.eric.ed.gov/

• For tips on keeping up to date on CMS-1500 completion guidelines for Medicare and Medicaid, log on to the CMS website and type “CMS-1500 Guidelines” into the search block.
  http://www.cms.hhs.gov/

• For specific instructions on completing a new CMS-1500 form for Medicare, refer to the Medicare Claims Processing Manual (beginning on page 7) at this web address:

• For additional information on the revised CMS-1500 form visit the NUCC website at http://www.nucc.org

• More information on electronic claims and/or clearinghouses is available on the Federal Register. Use the following web address, then key applicable words, such as “claims clearinghouse” or “electronic claims.” http://www.gpoaccess.gov/fr/index.html

• Specific and detailed instructions for completing claims using the new CMS-1500 (08-05) are given in the National Uniform Claim Committee’s instruction manual at http://www.nucc.org/images/stories/PDF/instruction_manual.pdf