



## Iowa Medicaid Enterprise CMS-1500 Claim Form Instructions Health Insurance Claim Form

The following Iowa Medicaid provider types bill for services on the CMS-1500 claim form: Ambulance, Ambulatory Surgical Centers, Area Education Agencies, Audiologists, Birthing Centers, Certified Registered Nurse Anesthetists, Chiropractors, Clinics, Community Mental Health Clinics, Family Planning Clinics, Federally Qualifying Health Centers, Hearing Aid Dealers, Independently Practicing Physical Therapists, Lead Investigation Agencies, Maternal Health Centers, Medical Equipment and Supply Dealers, Nurse Midwives, Opticians, Optometrists, Orthopedic Shoe Dealers, Physicians, Rural Health Clinics and Screening Centers.

The billing instructions below contain information that will aid in the completion of the CMS-1500 claim form. The table follows the claim form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

If you have any questions about this form or instructions, please contact IME Provider Services at 800-338-7909, or if within the local Des Moines area call 515-256-4609.

Field No.	Field Name/Description	Requirements	Instructions
1	Check One	<b>REQUIRED</b>	Check the applicable program.
1a.	Insured's ID Number	<b>REQUIRED</b>	Enter the Medicaid member's Medicaid number found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid Member is defined as the recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, i.e., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2	Patient's Name	<b>REQUIRED</b>	Enter the last name, first name, and middle initial of the Medicaid member.

3	Patient's Birth Date	OPTIONAL	Enter the birth date and sex of the member.
4	Insured's Name	OPTIONAL	For Medicaid purposes, this will always be the same as the patient. The insured: For Iowa Medicaid purposes, the member is the insured. If the member is covered through other insurance, the policy-holder is the "other insured".
5	Patient's Address	OPTIONAL	Enter the address and phone number of the patient, if available.
6	Patient Relationship to Insured	OPTIONAL	For Medicaid purposes, the insured will always be the same as the patient.
7	Insured's Address		
8	Reserved for NUCC Use	<i>SITUATIONAL</i>	If you are billing with unlisted CPT/ HCPCS codes; please clearly identify those by listing a description of the item or service.
9	Other Insured's Name	<i>SITUATIONAL</i>	REQUIRED if the Medicaid member is covered under other additional insurance enter the name of the policy holder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program. If 11d is "Yes", these boxes must be completed.
9a.	Other Insured's Policy or Group Number	<i>SITUATIONAL</i>	REQUIRED if the Medicaid member is covered under other additional insurance enter the name of the policy holder of that insurance <b>Note:</b> If 11d is "Yes", this box must be completed.
9b-c.	Reserved for NUCC Use	<b>LEAVE BLANK</b>	This field must be left blank.

9d.	Insurance Plan Name or Program Name	<i>SITUATIONAL</i>	REQUIRED if the Medicaid member is covered under other additional insurance. Enter the name of the plan or program.  <b>NOTE:</b> if 11d is “Yes”, this box must be completed.
10	Is Patient’s Condition Related To:	<i>SITUATIONAL</i>	REQUIRED if known. Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient’s condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the “YES” and “NO” boxes. The provider also needs to include the appropriate postal abbreviation for the PLACE (State) associated with the auto accident.
10a.	Employment?		
10b.	Auto Accident?		
10c.	Other Accident?		
10d.	Claim Codes (Designated by NUCC)	OPTIONAL	No Entry Required
11.	Insured’s Policy Group or FECA Number	OPTIONAL	For Medicaid purposes, the insured will always be the same as the patient.
11a	Insured’s Date of Birth & Gender	OPTIONAL	Enter date of birth in MM/DD/YY format. Select appropriate gender box.
11b.	Other Claim ID (Designated by NUCC)	OPTIONAL	No Entry Required
11c.	Insurance Plan Name or Program Name	OPTIONAL	For Medicaid purposes, the insured will always be the same as the patient.

11d.	Is There Another Health Benefit Plan?	<b>REQUIRED</b>	<p>REQUIRED if the Medicaid member has other insurance, check "YES" and enter payment amount in field 29. If "YES", then boxes 9a-9d must be completed.</p> <p>If there is no other insurance check "NO".</p> <p>If you have received a denial of payment from another insurance, check <u>both</u> "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.</p> <p>Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.</p> <p><b>Note:</b> Auditing will be performed on a random basis to ensure correct billing.</p>
12	Patient's or Authorized Person's Signature	OPTIONAL	No entry required.
13	Insured or Authorized Person's Signature	OPTIONAL	No entry required.

14	Date of Onset or Pregnancy (LMP) and Qualifier	<i>SITUATIONAL</i>	<p>Entry should be made in MM/DD/YY format. REQUIRED for Chiropractors. Chiropractors use the date of onset of current symptoms or illness.</p> <p>For pregnancy, use the date of the last menstrual period (LMP). This field is not required for preventative care.</p> <p>Qualifier 484 should be used when entering date of last menstrual period (LMP). Qualifier 431 should be used when entering the date for onset of current symptoms or illness.</p>
15	Other Date and Qualifier	<i>SITUATIONAL</i>	<p>REQUIRED for Chiropractors. Chiropractors <b>must</b> enter the date of the most current x-ray. Entry should be made in MM/DD/YY format.</p> <p>Qualifier 455 must be used when indicating x-ray date.</p>
16	Dates Patient Unable to Work in Current Occupation	OPTIONAL	No entry required.
17	Name of Referring Provider or Other Source	<i>SITUATIONAL</i>	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the Medipass provider or Lock In provider.
17a.	Untitled	<b>LEAVE BLANK</b>	This field must be left blank.

17b.	NPI	<i>SITUATIONAL</i>	<p>REQUIRED if:</p> <p>The patient is a MediPASS member and the MediPASS provider authorized the service, enter the 10-digit NPI of the referring MediPASS provider.</p> <p>If the patient is on Lock-In and the Lock-In provider authorized service, enter the 10-digit NPI of the Lock-In Primary Care Provider (PCP).</p>
18	Hospitalization Dates Related to Current Services	OPTIONAL	No entry required.
19	Additional Claim Information (Designated by NUCC)	<i>SITUATIONAL</i>	<p>Enter the NPI number of the referring or prescribing provider.</p> <p>If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider.</p> <p>This box is <b>Required</b> if referring/prescribing provider is <u>NOT</u> the same as the MediPASS provider or Lock-In PCP</p> <p>For MediPASS members if referring/prescribing provider is also the MediPASS provider or Lock-In PCP then this box is NOT required.</p>
20	Outside Lab	OPTIONAL	No entry required.

21	Diagnosis or Nature of Illness or Injury and ICD Indicator	<b>REQUIRED</b>	<p>Indicate the applicable ICD-9-CM diagnosis codes in order of importance (A-primary; B- secondary; C-tertiary; D-quaternary) to a maximum of twelve diagnoses.</p> <p>If the patient is pregnant, one of the diagnosis codes <b>must</b> indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648; 670 through 677; V22; V23.</p> <p><b>DO NOT</b> enter descriptions.</p> <p>Indicate a 9 for the ICD Ind. when submitting ICD-9-CM diagnosis codes.</p>
22	Resubmission Code	OPTIONAL	No entry required.
23	Prior Authorization Number	<i>SITUATIONAL</i>	REQUIRED if there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.
24A. top shaded portion	Date(s) of Service/NDC	<i>SITUATIONAL</i>	<p>REQUIRED for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs).</p> <p>No spaces or symbols should be used in reporting this information.</p>
24A. lower portion	Date(s) of Service	<b>REQUIRED</b>	<p>Enter month, day and year under both the From and To categories for each procedure, service, or supply.</p> <p>Entry should be made in MM/DD/YY format.</p>

<p>24b. lower portion</p>	<p>Place of Service</p>	<p><b>REQUIRED</b></p>	<p>Using the chart below, enter the number corresponding to the place service was provide. <b>DO NOT</b> use alphabetic characters.</p> <ul style="list-style-type: none"> <li>11 – Office</li> <li>12 – Home</li> <li>21 – Inpatient Hospital</li> <li>22 – Outpatient Hospital</li> <li>23 – Emergency room – hospital</li> <li>24 – Ambulatory surgical center</li> <li>25 – Birthing center</li> <li>26 – Military treatment facility</li> <li>31 – Skilled nursing...</li> <li>32 – Nursing facility</li> <li>33 – Custodial care facility</li> <li>34 – Hospice</li> <li>41 – Ambulance – land</li> <li>42 – Ambulance – air or water</li> <li>51 – Inpatient psychiatric facility</li> <li>52 – Psychiatric facility – partial hospitalization</li> <li>53 – Community mental health center</li> <li>54 – Intermediate care facility/mentally retarded</li> <li>55 – Residential substance abuse treatment facility</li> <li>56 – Psychiatric residential treatment center</li> <li>61 – Comprehensive inpatient rehabilitation facility</li> <li>62 – Comprehensive outpatient rehabilitation facility</li> <li>65 – End-stage renal disease treatment</li> <li>71 – State or local public health clinic</li> <li>81 – Independent laboratory</li> <li>99 – Other unlisted facility</li> </ul>
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24c. lower portion	EMG	OPTIONAL	No entry required.
24d. lower portion	Procedures, Services, or Supplies	<b>REQUIRED</b>	<p>Enter the codes for each of the dates of service.</p> <p><b>DO NOT</b> list services for which no fees were charged.</p> <p><b>DO NOT</b> enter the description.</p> <p>Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) or valid Current Procedural Terminology (CPT). When applicable, show HCPCS code modifiers with the HCPCS code.</p>
24e. lower portion	Diagnosis Pointer	<b>REQUIRED</b>	<p>Indicate the corresponding diagnosis code from field 21 by entering the letter of its position, i.e., C.</p> <p><b>DO NOT</b> enter the actual diagnosis code in this field, doing so will cause the claim to deny.</p> <p><b>Note:</b> There is a maximum of four diagnosis code pointers allowed per line.</p>
24f. lower portion	\$ Charges	<b>REQUIRED</b>	Enter the <u>usual</u> and <u>customary</u> charge for each line item billed. The charge must include both dollars and cents.
24g. lower portion	Days or Units	<b>REQUIRED</b>	Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia.

24h. lower portion	EPSDT/ Family Planning	<i>SITUATIONAL</i>	REQUIRED if services are a result of an EPSDT Care for Kids screen or are for family planning services.  Enter "F" if the service on this claim line is for family planning.  Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24i. top shaded	ID. Qual.	<b>LEAVE BLANK</b>	This field must be left blank.
24J. top shaded	Rendering Provider ID. #	<b>LEAVE BLANK</b>	This field must be left blank.
24J. lower portion	NPI	<b>REQUIRED</b>	Enter the NPI of the provider rendering the service.
25	Federal Tax I.D. Number	OPTIONAL	No entry required.
26	Patient's Account No.	OPTIONAL	Enter the patient account number assigned to the patient by the provider of service. This field is limited to 13 alpha/numeric characters.
27	Accept Assignment?	OPTIONAL	No entry required.
28	Total Charge	<b>REQUIRED</b>	Enter the total of the line item charges on the LAST page of the claim.  If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Charge. The pages prior to the last page should have "continued" or "page 1 of ____" in Box 28.

29	Amount Paid	<i>SITUATIONAL</i>	<p>REQUIRED if the member has other insurance <b>and</b> the insurance has made a payment on the claim. Enter only the amount paid by other insurance. Member co-payments, Medicare payments or previous Medicaid payments are not listed on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denials must be included in the patient record.</p> <p>If more than one claim form is used to bill services performed and a prior payment was made, the third-party payment should be entered on <b>each page</b> of the claim in Box 29.</p>
30	Reserved for NUCC/Local Use	<b>Leave Blank</b>	This field must be left blank.
31	Signature of Physician or Supplier	<b>REQUIRED</b>	<p>Enter the signature of either the physician or authorized representative and the original filing date. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.</p> <p>The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form.</p>
32	Service Facility Location Information	OPTIONAL	Enter the complete address of the treating/rendering provider.
32a.	NPI	OPTIONAL	Enter the NPI of the facility where service(s) were rendered.
32b.	Untitled	<b>LEAVE BLANK</b>	This field must be left blank.

33	Billing Provider Info & Phone #	<b>REQUIRED</b>	<p>Enter the name and complete address of the billing provider.</p> <p><b>Note:</b> The address <b>must</b> contain the zip code associated with the billing provider's NPI.</p>
33a.	NPI	<b>REQUIRED</b>	Enter the NPI of the billing provider.
33b.	Untitled	<b>REQUIRED</b>	<p>Enter the taxonomy code associated with the <b>billing provider's NPI</b>.</p> <p>A "<b>ZZ</b>" qualifier must precede the taxonomy code.</p>