Optum | Maryland

Completing the Paper CMS-1500 Form

The following information shows field by field description of required data elements in addition to the NPI requirements listed above.

Block 1: **Required**: Show all type(s) of health insurance applicable to this claim by checking the appropriate box (es).

Block 1a: INSURED'S ID NUMBER: **Required**: Claims must be submitted with either the participant's Medicaid Identification Number or the Optum Maryland assigned Member Identification Number. Claims submitted with a Social Security Number, including claims for Uninsured Eligible participants, will be rejected.

Block 2: PATIENT'S NAME (Last Name, First Name, and Middle Initial): **Required**: Enter the participant's name as it appears on the Medical Assistance card.

Block 3: PATIENT'S BIRTH DATE/SEX: **Required**: Enter the participant's birth date and gender. Use the eight-digit format (MM/DD/CCYY) format for date of birth. Enter an X in the correct box to indicate the patient's gender. Only one box can be marked. If the gender is unknown, leave blank

Block 4: INSURED'S NAME (Last Name, First Name, Middle Initial): **Optional**: Enter the name of the person in whose name the third-party coverage is listed, only when applicable. Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr., Sr.) enter it after the last name, but before the first name.

Block 5: PATIENT'S ADDRESS: **Required**: Enter the patient's (or participant's) complete mailing address with zip code and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number.

NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. If the patient is homeless, please indicate HOMELESS on the first line.

Block 6: PATIENT'S RELATIONSHIP TO INSURED: **Optional**: Enter the appropriate relationship should be entered only when there is third party health insurance

Block 7: INSURED'S ADDRESS: **Optional:** Enter the insured's address and telephone number when there is third party health insurance coverage.

Block 8: PATIENT STATUS: **Optional:** Check the appropriate box for the patient's marital status and whether employed or a student.

Block 9: OTHER INSURED'S NAME: **Required if Field 11d is marked "yes"** or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.)

Block 9a: OTHER INSURED'S POLICY OR GROUP NUMBER: **Required if Field 11d is marked "yes"** or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.

Block 9b: OTHER INSURED'S DATE OF BIRTH: **Required if Field 11d is marked "yes**" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.

Block 9c: EMPLOYER'S NAME OR SCHOOL NAME: **Required if Field 11d is marked "yes**" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.

Block 9d: INSURANCE PLAN OR PROGRAM NAME: **Required if Field 11d is marked "yes"** or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.

Block 10a thru 10c: IS PATIENT'S CONDITION RELATED TO: **Conditional**: Check "Yes" or "No". Place an "X" in the box indicating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.

Block 10d: RESERVED FOR LOCAL USE: **Not Required**. N/A

Block 11: INSURED'S POLICY GROUP OR FECA NUMBER: **Not Required**: Enter the Insured's policy or group number as it appears on the insured's health care identification card.

Block 11a: INSURED'S DATE OF BIRTH: **Not Required.** Enter the eight-digit date of birth in MM/DD/CCYY format.

Block 11b: EMPLOYER'S NAME OR SCHOOL NAME: **Not Required.** Enter the other insured's employer's name or school.

Block 11c: INSURANCE PLAN OR PROGRAM NAME: **Not Required.** Enter the other insured's insurance company or program name.

Block 11d: IS THERE ANOTHER BENEFIT PLAN?: **Conditional:** Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.

Block 12: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: **Required:** The patient must sign and date the claim if authorizing the release of medical information. If "signature on file" is indicated, the provider must maintain a signed release form or CMS-1500. The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.

Block 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: **Conditional:** The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature is acceptable. If there is no signature on file leave this item blank or enter "no signature on file".

Block 14: DATE OF CURRENT ILLNESS, INJURY, PREGNANCY: **Optional.** Enter the date of the participant's current illness, injury or pregnancy.

Block 15: IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: **Optional**. Enter the date the participant first had the same or similar illness.

Block 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: **Optional.** Enter the dates the participant was unable to work in their current occupation.

Block 17: NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **Required for outpatient laboratory claims:** Enter the name of the referring physician.

Block 17a: ID NUMBER OF REFERRING PHYSICIAN: **Conditional**: Enter the ID Qualifier.

Block 17b: NPI OF REFERRING PHYSICIAN: **Required for outpatient laboratory claims**: Enter the NPI of the referring, ordering, or supervising provider listed in Block 17.

Block 18: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: **Required if this claim includes charges for services rendered during an inpatient admission:** Enter dates in MMDDYY format.

Block 19: RESERVED FOR LOCAL USE: **Not required**. N/A

Block 20: OUTSIDE LAB: **Optional**. Enter the name of the outside laboratory.

Block 21: DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY: **Required:** Enter a valid ICD-10 diagnosis code (if entering in the Incedo Provider Portal, the diagnosis

must be entered without the decimal point), coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.) The primary diagnosis must be a covered PBHS Diagnosis Listing. The Diagnosis Listing can be found on the "Provider Resources" page at http://maryland.optum.com. Scroll down the page to "Clinical/Utilization Management" where ICD-10 diagnoses are listed.

Block 22: MEDICAID RESUBMISSION CODE AND ORIGINAL REF. NO.: **Conditional**: Enter the actual Medicaid Resubmission code for a previously paid, resubmitted claim, and list the original reference (claim) number for resubmitted claims.

Block 23: PRIOR AUTHORIZATION NUMBER: **Optional.** Enter the prior authorization number.

Block 24 A-G: NATIONAL DRUG CODE (NDC):

- Report the NDC/quantity when billing for drugs using the J-code HCPCS.
- Allow for the entry of 61 characters from the beginning of 24A to the end of 24G.
- Begin by entering the qualifier N4 and then the 11-digit NDC number. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits (5-4-2).
- Without skipping a space or adding hyphens, enter the unit of measurement qualifier followed by the numeric quantity administered to the patient.
- Below are the measurement qualifiers when reporting NDC units:

Measurement Qualifiers

F2 International Unit

GR Gram

ML Milliliter

UN Units (EA/Each)

ME Milligram

Example: NDC/Quantity Reporting

24A DATE(S) OF SERVICE FROM: TO: **D. PROCEDURES, SERVICES G. DAYS OR UNITS CPT/HCPCS**

MM DD YY MM DD YY

N400009737604ML1 (SHADED AREA)

01 01 08 01 01 08 J1055

More than one NDC can be reported in the shaded lines of Box 24. Skip three spaces

after the first NDC/Quantity has been reported and enter the next NDC qualifier, NDC number, unit qualifier and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDC"s. – Required

Block 24a: DATE(S) OF SERVICE: **Required**: Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2020 would be 06/01/20) under the FROM heading. Leave the space under the TO heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates are not accepted.

Block 24B: PLACE OF SERVICE: **Required:** For each date of service, enter the appropriate 2-digit place of service code.

Block 24C: EMG (emergency indicator): **Not required**.

Block 24D: PROCEDURES, SERVICES OR SUPPLIES: **Required:** Enter a valid CPT or HCPCS code for each service rendered. Enter a valid CPT or HCPCS code modifier, as applicable, for each service entered.

Block 24E: DIAGNOSIS POINTER: **Required:** Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, 1, 2, 3 or 4, is shown. Do not enter the ICD-10 diagnosis code.

Block 24F: CHARGES: **Required:** Enter the provider's usual and customary charges. Do not enter the Maryland Medicaid maximum fee unless that is the provider's usual and customary charge. PRP claims should bill the cascade rate schedule.

If there is more than one unit of service on a line, the charge for that line should be the total of all units.

Block 24G: DAYS OR UNITS: **Required**: Enter the total number of units of service for each procedure. The number of units must be for a single visit or day. Multiple, identical services rendered on different days should be billed on separate lines.

Block 24H: EPSDT FAMILY PLAN: **Not required**.

Block 24I: ID QUAL.: **Optional**: Enter the ID Qualifier 1D (Medicaid Provider Number). If the provider does not have a NPI, enter the appropriate qualifier and identifying number in the shaded area. Providers who do not have a NPI will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.

Block 24J: RENDERING PROVIDER ID #: **Required**: Enter the NPI number in the unshaded area of the field. Please refer to section 13.7 regarding NPI rules for rendering providers.

Block 25: FEDERAL TAX I.D. NUMBER: **Required**: Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered. Claims with an incorrect or missing Tax ID number will be denied.

Block 26: PATIENT'S ACCOUNT NUMBER: **Optional**: Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher.

Block 27: ACCEPT ASSIGNMENT: **Required**: Enter an "X" in the appropriate box. NOTE: Providers must accept payment by the Program as payment in full for covered service (in addition to applicable copay). No additional charge to any recipient may be made for covered services.

Block 28: TOTAL CHARGE: **Required**: Enter the sum of the charges shown on all lines of Block #24F of the invoice.

Block 29: AMOUNT PAID: **Required if there is third party liability**: Enter the amount of any collections received from any third-party payer or the patient. If there is other insurance, an EOB from the primary carrier must be submitted with the claim if the primary carrier payment is $0. If an EOB is not required for the service, it is not necessary to bill the primary carrier. See the list of service codes that don't require a primary carrier EOB at the following site: maryland.optum.com

Block 30: BALANCE DUE: (Block 28 minus Block 29 equals Block 30 "balance due": **Required if there is third party liability:** Enter the difference between Block 28 and Block 29.

Block 31: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS: **Required:** Enter the rendering provider's signature and degree/license level.

Block 32: SERVICE FACILITY LOCATION INFORMATION: **Conditional**: Facility where services were rendered.

Block 32a: NPI: **Conditional:** Enter the NPI of the service facility.

Block 32b: **Not required**.

Block 33: BILLING PROVIDER INFO & PH#: **Required:** Enter the name, complete street address, city, state, and zip code of the provider. This is the address to which payment should be made.

Block 33a: NPI: **Required**: Enter the NPI number of the billing provider in Block # 33. Error or omission of this number will result in non-payment of claims.

Block 33b: **Not required**.