PART B

J14 A/B MAC

CMS-1500 Claim Form Billing Guide

May 2011

NHIC, Corp.

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B CMS-1500 Claim Form Instructions. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-04, Chapter 26 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at http://www.cms.gov/manuals/

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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THE CMS-1500 CLAIM FORM

The Form CMS-1500 (Health Insurance Claim Form) is the standard claim form used by a non-institutional provider or supplier to bill Medicare contractors and durable medical equipment contractors when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.

The National Uniform Claim Committee (NUCC) is responsible for the maintenance of the form CMS-1500. CMS and contractors do not provide the form to providers for claim submission. Forms may be purchased from the U.S. Government Printing Office at (866) 512-1800, local printing companies in your area and/or office supply stores. Each of these sources sells the Health Insurance Claim Form CMS-1500 in various configurations (single part, multi-part, continuous feed, laser, etc.)

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. It has also been adopted by the TRICARE Program and has received the approval of the American Medical Association (AMA) Council on Medical Services. The latest version is CMS-1500 (08-05).

Providers and suppliers **must report** 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering 6 or 8-digit dates in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19, and a 6-digit date for item 24a. The same applies to providers and suppliers who choose to submit 6-digit dates. Items 12 and 31 are exempt from this requirement.

Intelligent Character Recognition (ICR)

NHIC is using an Intelligent Character Recognition (ICR) system to capture claims information directly from the CMS-1500 claim form.

ICR benefits include:

- Greater efficiency;
- Improved accuracy;
- More control over the data input, and
- Reduced data entry cost for the Medicare program.

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The ICR is capable of going beyond simply scanning claims data into the computer and has a sophisticated computer "brain" which verifies claims information against several data files as well as performing various claims processing functions.

With the ICR system, it is important that claims be submitted with proper and legible coding. This is because the ICR output is largely dependent on the accuracy and legibility of the claim form submitted.

If you are not billing electronically, consider it! However, when you bill on paper, follow these tips when completing your CMS-1500 forms:

The font should be:

- Legible (Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended)
- In Black Ink
- Pica, Arial 10, 11 or 12 font type
- CAPITAL letters

The font must NOT have:

- Broken characters
- Script, Italics or Stylized font
- Red ink
- Mini-font
- Dot Matrix font

Do NOT bill with:

- Liquid correction fluid changes.
- Data touching box edges or running outside of numbered boxes (left justify information in each box). **Exception:** when using the 8-digit date format, information may be typed over the dotted lines shown in date fields, i.e., Item 24a.
- More than six service lines per claim (use a new form for additional services);
- Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier or ICD-9-CM codes are sufficient);
- Stickers or rubber stamps (such as "tracer," "corrected billing," provider name and address, etc.);
- NHIC's address at top of the form;
- Special characters (i.e., hyphens, periods, parentheses, dollar signs and ditto marks).
- Handwritten descriptions;
- Attachments smaller than 8 1/2 x 11.

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The claim form must be:

- An original CMS-1500 printed in red "drop out " ink with the printed information on back (photocopies are not acceptable);
- Size - 8½" x 11" with the printer pin-feed edges removed at the perforations;
- Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
- Thick enough (20-22 lbs.) to keep information on the back from showing through;
- Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strike-overs, crossed-out information or white out.

NOTE: The following examples are in black and white. An original CMS-1500 claim form is printed in red "drop out" ink with the printed information on the back.

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY — SEX M F

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

5. PATIENT'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) — CITY — STATE — ZIP CODE — TELEPHONE (Include Area Code) ( )

8. PATIENT STATUS — Single Married Other — Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY — SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM | DD | YY — SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED ______ DATE ______

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) — a. NPI b.

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

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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.

REFERS 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 health plan or agency shown. In Medicare assigned or 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, 9, and 11.

BLACK LUNG AND FECA 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 as "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 bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am 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 COLLECTION AND USE 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 provisions that require other third parties payers 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 MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

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 Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private 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 adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

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 such services 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 0938-0999. 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, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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INSTRUCTIONS FOR FILLING OUT THE HEALTH INSURANCE CLAIM CMS FORM-1500

NOTE: Items marked with "R" (Required) or "C" (Conditionally Required) will cause your claim to be rejected if they are missing, invalid, or incomplete. However, there are many other items on the claim form which must be properly completed, or your claim will be developed, delayed or denied.

Publications (Pub.) referenced in the instructions refer to the CMS Internet Only Manual (IOM).

Reminder: For date fields other than date of birth, all fields shall 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.

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
X (Medicare #)	(Medicaid #)	(Sponsor's SSN)	(Member ID#)	(SSN or ID)	(SSN)	(ID)	987654321A

Item 1: ® Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

CONTRACTOR NOTE: Do not use dashes in number. Be sure to add the letter suffix.

Item 1a: ® Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) / SEX
DOE JANE		03 25 1919 M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED
453 NEW HAVEN STREET		Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: ANYWHERE	STATE: MA	
ZIP CODE: 56789	TELEPHONE (Include Area Code): (111) 555-1212	

Illustration for Items 2 though 6.

Item 2: ® Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.

Item 3: Enter the patient's 8-digit birth date (MM/DD/CCYY) and sex.

Item 4: © If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. **If Medicare is primary, leave blank.**

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Item 5: Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6: © Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7: © Enter the insured's address and telephone number. When the address is the same as the patient's, use the word SAME. Complete this item **only** when items 4, 6 and 11 are completed.

Item 8: Check the appropriate box for the patient's marital status and whether employed or a student.

8. PATIENT STATUS					
Single	X	Married		Other	
Employed		Full-Time Student		Part-Time Student	

Item 9: Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**

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

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the patient. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a patient elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

Medigap – A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of Title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare.

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It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
SAME
a. OTHER INSURED'S POLICY OR GROUP NUMBER
MEDIGAP 5556789
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX
03 25 1919 M [ ] F [X]
c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
55000

Illustration for Items 9 though 9d.

Item 9a: © Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed, *even when* the provider enters a policy and/or group number in Item 9a.

Item 9b: © Enter the Medigap insured's 8-digit birth date (MM/DD/CCYY) and sex.

Item 9c: © Leave blank if a Medigap PAYERID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two letter state postal code, and zip code copied from the Medigap insured's Medigap identification card.

For example:

1257 Anywhere Street
Baltimore, MD 21204
is shown as "1257 ANYWHERE ST MD 21204."

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

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If the Medicare beneficiary wants Medicare payment data forwarded to a Medigap insurer through the Medigap claim-based crossover process, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. A Medicare participating provider or supplier shall only enter the COBA Medigap claim-based ID within item 9d when seeking to have the beneficiary's claim crossed over to a Medigap insurer. If a participating provider or supplier enters the PAYERID or the Medigap insurer program or its plan name within item 9d, the Medicare Part B contractor will be unable to forward the claim information to the Coordinator of Benefits Contractor.

NOTE : The Medigap claim-based IDs that fall in the range of 55000 through 59999 can be found on the CMS website at:

http://www.cms.gov/COBAgreement/

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

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

YES X NO

b. AUTO ACCIDENT?

PLACE (State)

YES X NO

c. OTHER ACCIDENT?

YES X NO

10d. RESERVED FOR LOCAL USE

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

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

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11. INSURED'S POLICY GROUP OR FECA NUMBER
487329
a. INSURED'S DATE OF BIRTH MM DD YY 03 25 1919 SEX M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME
NHIC, Corp
c. INSURANCE PLAN NAME OR PROGRAM NAME
ABC HEALTH PLAN
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

Illustration for item 11 through 11d.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a-11c. Items 4, 6, and 7 must also be completed.

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

If there is **no** insurance primary to Medicare, enter the word "**NONE**" and then proceed to item 12.

11. INSURED'S POLICY GROUP OR FECA NUMBER
NONE
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

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

If a lab has previously collected and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in item 11 of Form CMS-1500 when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

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

- Group Health Plan Coverage:
    - —Working Aged;
    - —Disability (Large Group Health Plan); and
    - —End Stage Renal Disease.
- No-Fault and/or Other Liability; and
- Work Related Illness/Injury:
    - —Workers' Compensation;
    - —Black Lung; and
    - —Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

NOTE: See the *Medicare Secondary Payer Billing Guide* in the Publications section of our website: http://www.medicarenhic.com

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

Item 11b: © Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) retirement date preceded by the word "RETIRED."

Item 11c: © Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d: Leave blank. Not required by Medicare.

Item 12: ® The patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alpha numeric date (e.g., January 1, 2010) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements" (Pub. 100-4, Section 26). If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements" (Pub. 100-4, Section 26) may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient can not sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

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Note: This can be "Signature on File" and/or a computer generated signature.

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

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

Item 13: The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for service furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

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

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

Item 14: © Enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of current illness, injury, or pregnancy. For chiropractic services, enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of the initiation of the course of treatment and enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date in item 19.

Item 15: Leave blank. Not required by Medicare.

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

Item 17: © Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring service.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p) (1), and (s) and §§1814(a), 1832(a) (2) (F) (ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

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

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

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

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Ordering physician is a physician or, when appropriate, a non-physician practitioner, who orders non-physician services for the patient. See Pub. 100-02, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services; (prior to January 1, 2010)
- Durable medical equipment
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service (prior to January 1, 2010), submit the name of the physician who is supervising the limited licensed practitioner;

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		
JOE FEELGOOD , MD	17b.	NPI	1234567890

Illustration for Item 17 though 17b.

Item 17a: Leave blank. Not required by Medicare.

Item 17b: Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

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

Item 19: Enter either a 6-digit (MM/DD/YY) or an 8-digit (MM/DD/CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, the incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17b, and for the identification of the supervisor, see item 24J of this section.

Enter either a 6-digit (MM/DD/YY) or an 8-digit (MM/DD/CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of the Pub. 100-02 Medicare Benefits Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for contractor review.

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

NOTE: Include route of administration if various routes are available for administration.

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

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

NOTE: Contractors can accept up to four modifiers on a line. If more than four are needed, use the instructions listed above.

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Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, “Patient refuses to assign benefits” when the beneficiary absolutely refuses to assign benefits to a non participating physician/supplier who accepts assignment on the claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, “Testing for hearing aid” when billing services involving the testing of a hearing aid(s) to obtain intentional denial when other payers are involved.

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

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

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

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, Chapter 1, Section 30.2.9.1 for additional information.)

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)

Individuals and entities who bill for administration of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point[xx.x]). Examples for hemoglobin test: TR/R1/9.0. Example of Hematocrit tests: TR/R2/27.0

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Item 20: Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. **NOTE:** This is a required field when billing for diagnostic tests subject to anti-markup payment limitations**.**

Item 21: © Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 466 . 19 3. 464 . 00

2. 465 . 0 4. 034 . 0

E. DIAGNOSIS POINTER

Illustration for Item 21.

Item 22: Leave blank. Not required by Medicare.

Item 23: © Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval (PMA) number should also be placed here when applicable.

NOTE: The IDE/ PMA number has one alpha character and six numeric digits.

For physicians performing care plan oversight services, enter the NPI of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed. **NOTE:** Effective October 2, 2006, the requirement to include the Home Health Agency (HHA) or hospice provider number on a CPO claim is temporarily waived by CMS. There is currently no place on the HIPAA standard ASC X 12N 837 format to specifically include the HHA or hospice number. Submitted claims that include the HHA or hospice provider number will returned to the provider as unprocessable, until further notice.

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

NOTE: For ambulance claims, enter the zip code for the point of pick up in this field. More than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Suppliers must prepare a separate claim for each trip if the points of pickup are located in different ZIP codes. Claims without a ZIP code in item 23, or with multiple ZIP codes in item 23, will be returned as unprocessable.

23. PRIOR AUTHORIZATION NUMBER

05D1234567

*Illustration for item 23***.**

NOTE : Item 23 can contain only 1 condition. Any additional conditions must be reported on a separate Form CMS-1500.

Item 24: The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g., N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space fill the remaining positions (e.g. UN2 or F2999999).

Item 24A: ® Enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. The contractor will return as unprocessable if date of service extends more than 1 day and a valid "to" date is not present.

Item 24B: ® Enter the appropriate place of service code(s) from the list provided in Appendix B. Identify the location, using a place of service code, for each item used or service performed.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

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Item 24C: Leave blank. Not required by Medicare.

Item 24D: ® Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim.

The contractor will return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicted in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

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

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 466 . 19 3. 464 . 0

2. 465 . 0 4. 034 . 0

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER
1	04	01	2011	04	01	2011	11		99212					1
2	04	02	2011	04	02	2011	11		99212					2
3														

Illustration for Item 24E.

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Item 24F: ®

Enter the charge for each listed service.

F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
35.00	1		NPI	1234567890
55.00	1		NPI	1234567890
			NPI	

Illustration for Item 24F through 24J

Item 24G: ®

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

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

For anesthesia, show the elapsed time (minutes) in item 24G. Convert hours into minutes and enter the total minutes required for this procedure.

Beginning with dates of service on and after January 1, 2011, for ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a "0" before the decimal (e.g. 0.9). See Pub. 100-04, chapter 15, §20.2 for more information on loaded mileage and §30.1.2 for more information on reporting fractional mileage.

NOTE: This field should contain an appropriate numerical value. Contractors will program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, contractors shall automatically default "0.1" unit when total mileage units are missing in this field.

Item 24H: Leave blank. Not required by Medicare.

Item 24I: Leave blank. Not required by Medicare.

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Item 24J: Enter the rendering provider's NPI in the unshaded 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 NPI of the supervisor in the unshaded portion.

Providers with the following specialties should not be billing with a rendering provider NPI in item 24J of the CMS-1500 claim form:

- o Independent Diagnostic Treating Facility
- o Ambulatory Surgical Center
- o Individual Certified Orthotist
- o Individual Certified Prosthetist
- o Individual Certified Prosthetist/Orthotist
- o Ambulance Supplier
- o Public Health/Welfare Agencies (Federal, State or Local)
- o Voluntary Health Charitable Agency
- o Independently Billing Portable X-Ray
- o Independently Billing Clinical Lab
- o Mass Immunization Roster Billing
- o Radiation Therapy Centers
- o Slide Preparation Facilities

NOTE: It is no longer necessary for an individual provider (providers that have 1 NPI only) to enter his/her individual NPI in Item 24J as the rendering provider. Item 24J should be left blank. Claims will be returned as unprocessable if the rendering NPI is entered for an individual provider.

Item 25: Enter the provider of service or supplier Federal Tax I.D. (Employer Tax Identification number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26: Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

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

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

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse mid-wives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals and
- Simplified billing roster for influenza virus vaccine and pneumococcal vaccine

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

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

NOTE: We recommend this be left blank, as it is often misunderstood and can cause incorrect payments.

Item 30: Leave blank. Not required by Medicare.

Item 31: ® Enter the signature of the provider of service or supplier, or his/her representative, and either the 6-digit (MM/DD/YY) or 8-digit date (MM/DD/CCYY) date, or alphanumeric date (e.g., January 1, 2011) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field; however, the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32: Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one

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name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes, including home.

32. SERVICE FACILITY LOCATION INFORMATION MEDICARE, MEDICARE & MORE INC 1234 HEALTH CARE STREET ANYTOWN, MA 91234	
a. 1234567890 NPI	b. 1C FACILITY ID #

Illustration for Item 32 through 32b.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

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

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

Item 32a : If required by Medicare claims processing policy, enter the National Provider Identifier (NPI) of the service facility.

NOTE: At the present time, only claims for anti-markup diagnostic services require the entry of an NPI number .

Item 32b: Leave blank. Not required by Medicare.

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

Item 33a: Enter the NPI of the billing provider or group.

Item 33b: Leave blank. Not required by Medicare.

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APPENDIX A – SAMPLE WORDING FOR AUTHORIZATIONS

ONE-TIME AUTHORIZATION

For Use by Provider

Beneficiary Name____________________________HIC#___________________________

I request that payment of authorized Medicare benefits be made to me or on my behalf to (Provider Name) for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

____Date_________________
(Beneficiary signature)

For Use by a Facility

Beneficiary Name_______________________________________HIC#________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in (Name of Facility), including provider services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

____Date________________
(Beneficiary signature)

MEDIGAP AUTHORIZATION

Beneficiary Name____HIC#_______________
Medigap Policy Number_______________________________________

I request that payment of authorized Medigap benefits be made to either me or on my behalf to (Provider Name), for any services furnished to me by this provider. I authorize any holder of medical information to release to (Name of Medigap Insurer) any information needed to determine these benefits or the benefits payable for related services.

____Date_______________
(Beneficiary signature)

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APPENDIX B - PLACE OF SERVICE CODES WITH DEFINITIONS

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients
09	Prison-Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A

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11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	Effective May 1, 2010 A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

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22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

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43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

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57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

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NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: http://www.cms.gov/NationalCorrectCodInitEd/

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

FAX: 317-571-1745

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

FAX: 317-571-1745

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: http://www.cms.gov/BNI/

ABN Modifiers

GA Waiver of liability statement issued, as required by payer policy, individual case

GX Notice of liability issued, voluntary under payer policy

GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit

GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)
Note: All claim line items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

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NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

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If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services, LLC.
75 Sgt. William B. Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: ***1-800-HHS-TIPS (1-800-447-8477).*** Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversied Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on http://www.dcsrac.com/

COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

CERT DOCUMENTATION CONTRACTOR (CDC) - The CDC requests and receives medical records from providers.

CERT REVIEW CONTRACTOR (CRC)-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

For more information please click on http://www.cms.gov/CERT/

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Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or social security number (SSN) of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:
8:00 a.m. to 4:00 p.m. Monday – Thursday
10:00 a.m. to 4:00 p.m. - Friday
866-801-5304

Dedicated Reopening Requests Only
Hours of Operation:
8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday – Thursday
10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday
877-757-7781

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PROVIDER ENROLLMENT HELP LINE

A Customer Service Enrollment Specialist will be able to assist with your CMS-855 application inquiries. To help expedite your call, please have your CCN, PTAN and/or NPI number available.

Through the Provider Enrollment Help Line you can:
- Resolve your complex enrollment inquiries
- Schedule an appointment with a Provider Enrollment Specialist
- Receive individual assistance as you complete your PECOS Web Application

Toll Free Number (888) 300-9612
Phone Options:
- **Press 1** for Part B Application Inquiries
- **Press 2** for Part A and RHHI Application Inquiries
- **Press 3** if you are returning an application verification call
- **Press 4** if you need assistance completing your PECOS Web Application
- Or stay on the line for the next available representative.

Please note: The Provider Enrollment Help Line should not be used for checking status of your application. For application status inquiries, please visit our website at www.medicarenhic.com and go to "check enrollment status".

PROVIDER ENROLLMENT STATUS INQUIRY TOOL

This inquiry tool can be used to check on the status of your CMS-855 application.
http://www.medicarenhic.com/ne_prov/PartB_enrollment_search_form.shtml

The three possible statuses would be:
Screening: The application is being reviewed for signatures, missing sections/documents
Processing: Information on the application is being verified or request for additional information is in process
Finalized: The application has been approved, returned, rejected or denied

How to Search:
Individual Application: Type in your last name and first name
Group Application: Type in your Group Name

Note: The search results will be limited to the last six months of application activity. For any information beyond this timeframe, please contact Customer Service

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MAILING ADDRESS DIRECTORY

Initial Claim Submission	
Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 809150 Chicago, IL 60680-9150
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

****Note:** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the NHIC Corp. Clerical Error Reopening Request Form that can be downloaded from our Web site:

http://www.medicarenhic.com/ne_prov/forms.shtml

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PROVIDER SERVICES PORTAL (PSP)

The Provider Services Portal (PSP) is a website tool that offers the provider community an alternative to the IVR or Customer Service Toll Free line.

This tool offers the following information through lookup transactions **and there is no charge to access the PSP**:

- Beneficiary Eligibility
- Claim Status
- Standard Paper Remittances with the ability to select and print SPR's locally
- Provider Summary
- Provider Enrollment Status

The PSP has superior search capability and will allow you to research your claims quickly and efficiently! The PSP is available 24 hours a day, 7 days a week, except during scheduled maintenance windows.

How To Get Started: http://www.medicarenhic.com/ne_prov/psphome_index.shtml

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp. **Provider Service Line:** 1-866-419-9458

Please view the website to find the appropriate address:
http://www.medicarenhic.com/dme/contacts.shtml

RECONSIDERATION (SECOND LEVEL OF APPEAL)

C2C Solutions, Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

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INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

http://www.medicarenhic.com

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:
http://visitor.constantcontact.com/email.jsp?m=1101180493704

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links
From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

http://www.cms.gov/center/coverage.asp
http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

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Medicare Learning Network

http://www.cms.gov/MLNGenInfo/
The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

http://www.cms.gov/OpenDoorForums/
CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

http://www.cms.gov/CMSForms/

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)	**http://cms.gov/BNI/**
American Medical Association	**http://www.ama-assn.org/**
CMS	**http://www.cms.gov** **http://www.medicare.gov**
CMS Correct Coding Initiative	**http://www.cms.gov/NationalCorrectCodInitEd/**
CMS Physician's Information Resource for Medicare	**http://www.cms.gov/center/physician.asp**
Clinical Lab Improvement Amendment	**http://www.cms.gov/CLIA/01_Overview.asp#TopOfPage**

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Electronic Prescribing http://www.cms.gov/erxincentive/

Electronic Health Records http://www.cms.gov/ehrincentiveprograms/

Evaluation and Management Documentation Guidelines
http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

Federal Register http://www.archives.gov/federal-register
http://www.gpoaccess.gov/index.html

HIPAA http://www.cms.gov/HIPAAGenInfo/

ICD-10 http://www.cms.gov/icd10/

National Provider Identifier (NPI) http://www.cms.gov/NationalProvIdentStand/

NPI Registry
https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

Physicians Quality Reporting System http://www.cms.gov/PQRS//

Provider Enrollment, Chain, and Ownership System (PECOS)
http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment
http://www.cms.gov/MedicareProviderSupEnroll/

Skilled Nursing Facility Consolidated Billing
http://www.cms.gov/snfconsolidatedbilling/01_overview.asp?

U.S. Government Printing Office http://www.gpoaccess.gov/index.html

Washington Publishing Company http://www.wpc-edi.com/

5010 http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage

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Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Susan Kimball	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal
2.0	08/27/2010	M. Franco	Ayanna YanceyCato	Updated CMS addresses and Refunds Bank info
3.0	10/15/10	Susan Kimball	Ayanna Yancey Cato	Updated QIC name
4.0	05/12/11	Susan Kimball	Ayanna Yancey-Cato	Annual Review, updated 5 digits for Medigap, added ambulance mileage in 24G, added POS home for 32

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CMS Websites
http://www.cms.gov
http://www.medicare.gov