HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE ☐ (Medicare#)   MEDICAID ☐ (Medicaid#)   TRICARE ☐ (ID#/DoD#)   CHAMPVA ☐ (Member ID#)   GROUP HEALTH PLAN ☐ (ID#)   FECA BLK LUNG ☐ (ID#)   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)

6. PATIENT RELATIONSHIP TO INSURED   Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY   STATE

8. RESERVED FOR NUCC USE

CITY   STATE

ZIP CODE   TELEPHONE (Include Area Code) ( )

ZIP CODE   TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY   **SEX** M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO   PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY   QUAL.

15. OTHER DATE QUAL.   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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)   ICD Ind. ___

A. ___ B. ___ C. ___ D. ___
E. ___ F. ___ G. ___ H. ___
I. ___ J. ___ K. ___ L. ___

22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER

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

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. Rsvd for NUCC Use

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-0938-1197 FORM 1500 (02-12)

1500 Claim Form Instructions

Providers must use the 1500 Claim Form when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program (KMAP). Claims can be submitted on the KMAP secure website, as an electronic 837 file, through Provider Electronic Solutions (PES), or on an original, red ink 1500 paper claim form version 02/12. When a paper claim is submitted for a KMAP beneficiary, KMAP must be indicated on the form and the form should be completed using the instructions indicated below. Claims not meeting these submission requirements will be returned to the provider. KanCare (managed care) claims should be submitted to the appropriate KanCare managed care organization (MCO).

The fiscal agent does not furnish the paper 1500 Claim Form to providers. The form must be obtained from a claim form supplier, such as the ones listed below.

- **Administrative Services of Kansas, Inc.**
  PO Box 3500
  Topeka, KS 66601-0110
- **Advantage Business Forms**
  PO Box 67176
  Topeka, KS 66667
  785-235-6868
- TFP Data Systems
  1-800-482-9367, ext. 58029
- The Government Printing Office
  1-866-512-1800

Send completed paper claim to:
Kansas Medical Assistance Program
Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

For additional information regarding the approved version of the 1500 Claim Form, refer to the National Uniform Claim Committee (NUCC) website.

Note: For all paper claims, the Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

1500 Claim Form Instructions

Billing Instructions
The following numbered fields are to be completed when required or if applicable.

NOTE: **For all fields requiring a National Provider Identifier (NPI), the associated provider must be enrolled with KMAP and have a valid NPI on file for the claim to be considered for payment. Reference Section 2000 of the** *General Benefits Fee-for-Service Provider Manual.*

NOTE: **Fields with an * are not required for fee-for-service Medicaid claims.**

Field 1   **PROGRAM IDENTIFICATION**
Check appropriate box(es).

Field 1a   **INSURED'S ID NUMBER**
Enter the 11-digit beneficiary ID number from beneficiary's KMAP ID card. If newborn services, use mother's beneficiary ID number if newborn's number is unknown.

Field 2   **PATIENT'S NAME**
Enter the beneficiary's last name, first name, and middle initial exactly as it appears on the medical ID card. If the patient is a newborn, enter *newborn*, *baby boy*, or *baby girl*, in the first name field and enter the last name.

Field 3   **PATIENT'S DATE OF BIRTH**
Enter the beneficiary's date of birth as month, day, and year - MM/DD/YYYY (such as October 1, 1957 would be listed as 10/01/1957). If newborn services, enter the baby's date of birth (not the mother's).

                   PATIENT'S SEX
Check the appropriate box.

Field 4*   **INSURED'S NAME**
Enter the beneficiary's full last name, first name, and middle initial. If the beneficiary uses a last name suffix (such as, Jr or Sr), enter it after the last name and before the first name. Titles (such as, Sister, Capt, or Dr) and professional suffixes (such as, PhD, MD, or Esq) should not be included.

Field 5   **PATIENT'S ADDRESS**
Enter the beneficiary's street address including city, state, and ZIP code.

Field 6*   **PATIENT RELATIONSHIP TO INSURED**
Place an X in the corresponding box to indicate the patient's relationship to insured when Field 4 is completed. Only mark one box.

Field 7*   **INSURED'S ADDRESS**
Enter the beneficiary's address. If Field 4 is completed, then this field should be completed by entering the street address including city, state, and ZIP code.

Field 9   **OTHER INSURED'S NAME**
If the beneficiary has secondary or supplemental insurance, complete Fields 9, 9a, and 9d. (Enter the primary insurance information in Field 11.)

Field 10   **IS PATIENT'S CONDITION RELATED TO**

1500 Claim Form Instructions

Check the appropriate box when billing for **accident-related services only**.
If a box is checked, enter all available information in Field 11.

Field 11   **INSURED'S POLICY GROUP OR FECA NUMBER**
This field should be completed if the beneficiary has insurance primary to Medicaid. If yes, complete Fields 11a-d.

Field 12*   **PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**
Enter "Signature on file", "SOF", or legal signature. If legal signature, enter the date signed in six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format. If there is not a signature on file, leave blank or enter "No signature on file".

Field 13   **INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**
Enter "Signature on file", "SOF", or legal signature. If there is not a signature on file, leave blank or enter "No signature on file".

Field 14   **DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)**
Enter the eight-digit date (MM/DD/YYYY) of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported.
- 431 – Onset of current symptoms or illness
- 484 – Last menstrual period

Field 15*   **OTHER DATE**
Enter the date related to the patient's condition or treatment. Enter the date in an eight-digit date format (MM/DD/YYYY). Enter the applicable qualifier to identify which date is being reported.
- 090 – Report start (assumed care date)
- 091 – Report end (relinquished care date)
- 304 – Latest visit or consultation
- 439 – Accident
- 444 – First visit or consultation
- 453 – Acute manifestation of a chronic condition
- 454 – Initial treatment
- 455 – Last X-ray
- 471 – Prescription

Field 16*   **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**
Enter a six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date in the from-to dates area if the patient is employed and is unable to work in current occupation.

Field 17   **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**
Enter the name of the referring, ordering, or supervising physician for the following types of claims:
- Those filed by a consultant for consultation services
- Those filed by laboratory and radiology services
- Those filed by a provider who has rendered services to a lock-in beneficiary

Enter the applicable qualifier to the left of the vertical, dotted line.

1500 Claim Form Instructions

- DN Referring provider
- DK Ordering provider
- DQ Supervising provider

Claims billed by the following provider types must enter the name of the ordering or referring provider.

Note: For hospice beneficiaries ONLY who reside in a NF, ICF-IID, or hospital swing bed, enter the name of the facility in Field 17.

- 05 Home Health Agency
- 17 Therapist
- 24 Pharmacy
- 25 DME/Medical Supply Dealer
- 28 Laboratory
- 29 X-ray Clinic

Note: The ordering provider name should be submitted if the claim contains both an ordering and referring provider.

Field 17a **ID NUMBER OF REFERRING PHYSICIAN**
This field is used to capture the KMAP ID or taxonomy code for the referring, ordering, or supervising physician. The field should NOT be used if either:

- The referring, ordering, or supervising physician is required to use their NPI number. OR
- The referring, ordering, or supervising physician information is not required to be sent.

If the referring or ordering provider does not have an NPI number and is required to be reported, use the following qualifiers.

- Enter qualifier G2 (Provider Commercial Number) and the 10-digit KMAP provider ID of the referring or ordering physician.
- Enter all nines if the referring or ordering physician is not a KMAP provider.

If the supervising provider does not have an NPI number and is required to be reported, use the following qualifiers.

- Enter qualifier LU (Location Number) and the 10-digit KMAP provider ID of the supervising physician
- Enter all nines if the supervising physician is not a KMAP provider.

Note: In accordance with the NUCC manual, qualifier LU is used for the supervising provider only.

Field 17b **PROVIDER'S NPI**
Enter the HIPAA NPI of the referring, ordering, or supervising physician.
Claims billed by the following provider types must enter the NPI of the referring or ordering provider on the claim.

- 05 Home Health Agency
- 17 Therapist
- 24 Pharmacy
- 25 DME/Medical Supply Dealer
- 28 Laboratory
- 29 X-ray Clinic

1500 Claim Form Instructions

> *Note:* The ordering provider NPI should be submitted if the claim contains both an ordering and referring provider.

> *Note:* The referring, ordering, or supervising physician must also be enrolled with KMAP with a valid NPI for the claim to be considered for payment.

Field 18   **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**
Enter dates of admission and discharge.

Field 19*   **ADDITIONAL CLAIM INFORMATION**
If the field is required by the payer, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and number.

Field 20   **OUTSIDE LAB**
Check appropriate box:
- If no, bill for procedures performed.
- If yes, provider who actually performed service must bill.

Field 21   **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
Enter the diagnosis code and applicable ICD indicator, 9 for ICD-9 diagnoses or 0 for ICD-10 diagnoses, as appropriate.

Field 22   **RESUBMISSION**
List the original reference number for resubmitted claims.

Field 23   **PRIOR AUTHORIZATION NUMBER**
Enter the assigned prior authorization (PA) number from the approval letter, when applicable.

Field 24   **SUPPLEMENTAL INFORMATION**
Enter in the shaded areas of the numbered rows, as appropriate.
- Narrative description of unspecified codes
- National Drug Codes (NDCs) for drugs
- Contract rate
- Tooth numbers and areas of the oral cavity

For complete information on supplemental items, reference the [NUCC CMS 1500 Claim Form Reference Instruction Manual](#) on the [NUCC](#) website.

Field 24A   **DATE(S) OF SERVICE**
Enter the date of service in MM/DD/YY format. If multiple services were performed on **consecutive** dates, put the beginning date in the **From** field and the last date of service in the **To** field and complete the **Units** field (24G) accordingly.

Field 24B   **PLACE OF SERVICE**
Enter the appropriate place of service (POS) code for each service. Not all of the POS codes may be appropriate for the service provided. Indicate the POS code that most accurately reflects where the service was provided.
> 11 – Office
> 12 – Home
> 19 – Off campus outpatient hospital

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21 – Inpatient hospital
22 – On campus outpatient hospital
23 – Emergency room – hospital
24 – Ambulatory surgical center
31 – Skilled nursing facility
32 – Nursing facility
33 – Custodial care facility
34 – Hospice
41 – Ambulance – land
42 – Ambulance – air or water
50 – Federally Qualified Health Center (FQHC)
53 – CMHC
54 – ICF/IID
65 – End-stage renal disease treatment facility
71 – Local health department
72 – Rural Health Clinic (RHC)
81 – Independent laboratory
99 – Other locations

Field 24C*****   **EMG**
If this field is required by the payer, in the bottom, unshaded area, enter Y for "Yes" or leave blank for "No".

Field 24D   **PROCEDURES, SERVICES, OR SUPPLIES**
Enter the HCPCS five-digit base procedure code (add modifier[s] if appropriate). Explain unusual circumstances.

Field 24E   **DIAGNOSIS CODE**
Enter the appropriate line alpha character from Field 21.

Field 24F   **CHARGES**
Enter your **usual** and **customary** charge for each service.

Field 24G   **DAYS OR UNITS**
Enter the number of visits, days, or units of service rendered, as applicable to each detail line. FQHCs and RHCs should bill only one encounter per claim detail.

Field 24H   **EPSDT FAMILY PLAN**
COB: (EPSDT/KBH referral value)
- Enter the two-digit value when an EPSDT (KBH) screen results in a referral.
- The value choices include:
  - AV – The beneficiary refused the referral.
  - S2 – The beneficiary is currently under treatment.
  - ST – New services requested.

EPSDT / Family Planning:
- Enter E when completing an EPSDT (KBH) screen.
- Enter F when completing a family planning visit.
- Enter B when both an EPSDT (KBH) and family planning visit are completed.

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Field 24I   **ID QUALIFIER**
Enter qualifier G2 if billing with a KMAP provider ID in the top half of Field 24J. Enter qualifier PXC if billing with a taxonomy code in the top half of Field 24J.

Field 24J   **RENDERING PROVIDER ID #**
Enter in the top half a 10-digit KMAP provider ID or a taxonomy code. Enter in the bottom half the provider's NPI.

Field 25*****   **FEDERAL TAX ID NUMBER**
Enter the federal tax ID number (employer ID number or SSN) of the billing provider identified in Item Number 33. Place an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Field 26   **YOUR PATIENT'S ACCOUNT NUMBER**
OPTIONAL: Any alpha/numeric character entered in this field will be referenced on the remittance advice (RA). No unique characters should be indicated, such as *, @, -, or #.

Field 27   **ACCEPT ASSIGNMENT**
Leave blank. All KMAP providers must accept assignment in order to receive payment on a Medicare-related claim.

Field 28   **TOTAL CHARGE**
- Enter the total of all the itemized charges on this page of the claim. **(Do not include copayment amount. Refer to Section 8100 of each individual provider manual.)**
- When more than one claim page is used for the same beneficiary, for the same date of service, follow the instructions below:
    - Ensure that multiple pages of the claims are sent to Medicaid together.
    - Do not total the charges in Field 28 on each claim form. Only total all itemized charges (on all claim forms) on the last claim page.
    - Enter *Continued. Page __ of __* in Field 28. For example, when 10 procedures were provided for the same beneficiary on the same date of service enter *Continued. Page 1 of 2*.
    - Enter the total charge in Field 28 of the last page of the claim form. According to the example above, the total charge would be in Field 28 on Page 2.

Field 29   **AMOUNT PAID**
Enter any amount paid by insurance or other third-party sources known at the time the claim is submitted on the last claim page submitted. If the amount shown in this field is the result of other insurance, documentation of the payment must be attached. (Field 11 must identify the other insurance source.) Refer to Sections 3200 and 3300 of the *General Third Party Liability Payment Provider Manual* for more specific information. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**
Note: Retain proof of other insurance payment in the beneficiary's file.

Field 31   **SIGNATURE OF PHYSICIAN OR SUPPLIER**
Read the statement on the back of the claim form, sign, and date.
- Phrase *Signature on file* is acceptable.
- Provider's name typed or stamped is acceptable.

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Field 32 **SERVICE FACILITY LOCATION INFORMATION**
Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. If the service facility location is a component or subpart of the billing provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and Service Facility Location is not used. When reporting an NPI in the Service Facility Location, the entity must be an external organization to the billing provider. Submission of the location where the service was rendered is required for all POS codes. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. Only one name, address, and ZIP code can be entered in the block.

Note: **The service facility location address must be a street address or physical location, not a PO Box.**

Field 32a **PROVIDER'S NPI**
Enter the provider's NPI.

Field 32b **OTHER ID NUMBER – SERVICE FACILITY**
Enter qualifier G2 and the 10-digit KMAP provider ID or qualifier PXC and a taxonomy code.

Field 33 **BILLING PROVIDER INFO & PH #:**
Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:
- 1st Line – Name
- 2nd Line – Address
- 3rd Line – City, State, and ZIP Code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between the town name and state code; do not include a comma. Report a nine-digit ZIP code, including the hyphen. Do not use a hyphen or space as a separator within the telephone number. If reporting a foreign address, contact the payer for specific reporting instructions.

Note: **The billing provider address must be a street address or physical location, not a PO Box.**

Field 33a **PROVIDER'S NPI**
- Enter the provider's NPI.
- If a paper claim is submitted directly to the fiscal agent, the NPI is required in this field. All provider types and specialties must comply with this requirement, except most of provider type 55 (HCBS). The following HCBS (55) specialties must also comply:
  - o 237 – Targeted Case Management
  - o 514 – Wellness Monitoring - FE
  - o 515 – Nursing Evaluation

- o 517 – Wellness Monitoring – I/DD
- o 521 – Specialized Medical Care RN – I/DD
- o 523 - Specialized Medical Care LPN – I/DD
- o 532 – Home Telehealth
- o 550 – Autism Specialist
- o 551 – Intensive Individual Support - AU
- o 553 – Parent Support - AU
- o 554 – Family Adjustment Counseling - AU
- o 555 – Case Management/Care Coordination - TA
- o 560 – Health Maintenance Monitoring
- o 561 – Intermittent Intensive Medical Care

Field 33b   **KMAP PROVIDER ID OR TAXONOMY CODE**
Enter qualifier G2 and the 10-digit KMAP provider ID or qualifier PXC and a
taxonomy code.