Interactive CMS-1500 (02/12) Claim Form

Interactive CMS-1500 (02/12) Claim Form

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Item 1 - Type of Health Insurance

Shows the type of health insurance coverage applicable to this claim by the appropriately checked box; check the Medicare box.

837P Professional Version 5010/5010A1:

- Loop ID 2000B
- Segment/Data Element - SBR09

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Item 1a - Insured's ID Number

Enter the patient's Medicare ID whether Medicare is the primary or secondary payer. This is a required field

837P Professional Version 5010/5010A1:

- Loop ID 2010BA
- Segment/Data Element - NM109

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Item 2 - Patient's Name

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.

837P Professional Version 5010/5010A1:

- Loop ID 2010CA or 2010BA
- Segment/Data Element:
    - NM103
    - NM104
    - NM105
    - NM107

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Item 3 - Patient's Birth Date & Sex

Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

837P Professional Version 5010/5010A1:

- Loop ID 2010CA or 2010BA
- Segment/Data Element:
    - DMG02
    - DMG03

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Item 4 - Insured's Name

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.

837P Professional Version 5010/5010A1:

- Loop ID 2010BA
- Segment/Data Element:
  - NM103
  - NM104
  - NM105
  - NM107

Item 5 - Patient's Address

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.

837P Professional Version 5010/5010A1:

- Loop ID 2010CA
- Segment/Data Element:
  - N302
  - N401
  - N402
  - N403

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Item 6 - Patient Relationship to Insured

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

837P Professional Version 5010/5010A1:

- Loop ID 2000B
- Segment/Data Element:
    - SBR02
- Loop ID 2000C
- Segment/Data Element:
    - PAT01

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Item 7 - Insured's Address

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

837P Professional Version 5010/5010A1:

- Loop ID 2010BA
- Segment/Data Element:
    - N301
    - N302
    - N401
    - N402
    - N403

Item 8 - Reserved for NUCC Use (previously Patient Status)

Leave blank.

837P Professional Version 5010/5010A1:

- Loop ID N/A
- Segment/Data Element:
  - N/A

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Item 9 - Other Insured's Name

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.

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy." 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.

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 A/B MAC (B) or DME MAC to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

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837P Professional Version 5010/5010A1:

- Loop ID 2330A
- Segment/Data Element:
  - NM103
  - NM104
  - NM105
  - NM107

Item 9a - Other Insured's Policy or Group Number

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.

837P Professional Version 5010/5010A1:

- Loop ID 2320
- Segment/Data Element:
  - SBR03

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Item 9b - Reserved for NUCC Use (previously Other Insured's Date of Birth, Sex)

Leave blank.

837P Professional Version 5010/5010A1:

- Loop ID N/A
- Segment/Data Element:
  - o N/A

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Item 9c - Reserved for NUCC Use (previously Employer's Name or School Name)

Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter 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."

837P Professional Version 5010/5010A1:

- Loop ID N/A
- Segment/Data Element:
    - N/A

Item 9d - Insurance Plan Name or Program Name

Enter the Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID). Refer to chapter 28, section 70.6.4, of the Medicare Claims Processing Manual for more information.

837P Professional Version 5010/5010A1:

- Loop ID 2320
- Segment/Data Element:
  - SBR04

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Item 10a through 10c - Is Patient's Condition Related to: Employment, Auto Accident, Other Accident

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.

837P Professional Version 5010/5010A1:

- Loop ID 2300 (Items 10a - 10c)
- Segment/Data Element:
    - o CLM11 (Items 10a - 10c)

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Item 10d - Claim Codes (previously Reserved for Local Use)

Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - HI

Item 11 - Insured's Policy, Group, or FECA Number

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.

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.

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

Note: Enter the word **NONE** if Medicare is primary.

837P Professional Version 5010/5010A1:

- Loop ID 2000B
- Segment/Data Element:
    - SBR03

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Item 11a - Insured's Date of Birth, Sex

Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

837P Professional Version 5010/5010A1:

- Loop ID 2010BA
- Segment/Data Element:
    - o DMG02
    - o DMG03

Item 11b - Other Claim ID (previously Insured's Employer Name or School Name)

Form version 08/05: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word, "RETIRED."

Note: You must choose the same date format for items 11b, 14, 16, 18, 19 and 24a.

Form version 02/12: provide this information to the right of the vertical dotted line.

837P Professional Version 5010/5010A1:

- Loop ID 2010BA
- Segment/Data Element:
  - REF01
  - REF02

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Item 11c - Insurance Plan Name or Program Name

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.

837P Professional Version 5010/5010A1:

- Loop ID 2000B
- Segment/Data Element:
  - o SBR04

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Item 11d - Is there another Health Benefit Plan?

Leave blank. Not required by Medicare.

837P Professional Version 5010/5010A1:

- Loop ID 2320
- Segment/Data Element:
  - N/A

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Item 12 - Patient's or Authorized Person's Signature

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, 1998) 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." If the patient is physically or mentally unable to sign, a representative specified in chapter 1, 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, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

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

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    o CLM09

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Item 13 - Insured's or Authorized Persons Signature

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, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made.

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.

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837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - CLM08

Item 14 - Date of Current Illness, Injury, Pregnancy (LMP)

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

Note: You must choose the same date format for items 11b, 14, 16, 18, 19 and 24a.

Additional information for form version 02/12: Although this version of the form includes space for a

qualifier, Medicare does not use this information; do not enter a qualifier in item 14.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - DTP01
    - DTP03

Item 15 - Other Date (previously If Patient Has Had Same or Similar Illness)

Leave blank.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - DTP01
    - DTP03

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Item 16 - Dates Patient Unable to Work in Current Occupation

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

Note: You must choose the same date format for items 11b, 14, 16, 18, 19 and 24a.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    o DTP03

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Item 17 - Name of Referring Provider or Other Source

Enter the name of the referring physician and one of the qualifiers below (to the left of the dotted vertical line) to identify the role the physician (or non-physician practitioner) is performing:

- DN - Referring Provider
- DK - Ordering Provider
- DQ - Supervising Provider

Note: When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

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.

All claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

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837P Professional Version 5010/5010A1:

- Loop ID 2310A (Referring), 2310D (Supervising), 2420E (Ordering)
- Segment/Data Element:
    - NM101
    - NM103
    - NM104
    - NM105
    - NM107

Item 17a - Other ID#

Leave blank.

837P Professional Version 5010/5010A1:

- Loop ID 2310A (Referring), 2310D (Supervising), 2420E (Ordering)
- Segment/Data Element:
    - REF01
    - REF02

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Item 17b - NPI#

Enter the NPI of the referring, ordering, or supervising physician or non-physician practitioner listed in item 17. All physicians and non-physician practitioners who order services or refer Medicare beneficiaries must report this data.

837P Professional Version 5010/5010A1:

- Loop ID 2310A (Referring), 2310D (Supervising), 2420E (Ordering)
- Segment/Data Element:
    o NM109

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Item 18 - Hospitalization Dates Related to Current Services

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

Note: You must choose the same date format for items 11b, 14, 16, 18, 19 and 24a.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    o DTP03

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Item 19 - Additional Claim Information (previously Reserved for Local Use)

Enter additional claim information in this item. Possible entries are below:

- X-ray date for chiropractic services
- Drug name and dosage for Not Otherwise Classified (NOC) drugs
- Concise description of an unlisted procedure code
- Applicable modifiers when modifier 99 is used
- Specific surgery for dental examinations
- Demonstration ID number 30 for all national emphysema treatment trial claims
- Enter the date the patient was last seen and the attending physician's NPI who performs the routine foot care.
- 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.
- Enter assumed and or relinquished date for a global surgery claims when providers share post-operative care.

Note: You must choose the same 6–digit (MM DD YY) or 8-digit (MM DD CCYY) format for items 11b, 14, 16, 18, 19 and 24A.

See CMS IOM Pub 100-04, Chapter 26, Section 10.4 for guidance on completion of Item 19.

- 837P Professional Version 5010/5010A1:
  Loop ID 2300
- Segment/Data Element:
  - NTE
  - PWK
- Loop ID 2310A (Referring), 2310B (Rendering), 2310C (Service Facility), 2310D, (Supervising)
- Segment/Data Element:
  - REF01
  - REF02

Item 20 - Outside Lab Charges

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 the anti-markup payment limitation. See CMS IOM Pub 100-04, Chapter 1 for additional information on anti-markup payment limitation.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
  - PS102

Item 21 - Diagnosis or Nature of Illness or Injury

Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use diagnosis codes to the highest level of specificity for the date of service. Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Enter up to 12 diagnosis codes. Note that this information appears opposite lines with letters A-L. Relate

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lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Reminder: Do not report ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10-CM.

Do not insert a period in the ICD-9-CM or ICD-10-CM code.
The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - HI01-2, HI02-2
    - HI03-2, HI04-2
    - HI05-2, HI06-2
    - HI07-2, HI08-2
    - HI09-2, HI10-2
    - HI11-2, HI12-2

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Item 22 - Diagnosis or Nature of Illness or Injury

Leave blank. Not required by Medicare.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
  - CLM05-3
  - REF02

Item 23 - Prior Authorization Number

- 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 number should also be placed here when applicable.
- 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.
- Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.
- For ambulance claims, enter the ZIP code of the loaded ambulance trip's point-of-pickup.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate CMS-1500 claim form.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
  - REF02

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Item 24A - Date(s) of Service

Enter a 6-digit or 8-digit (MMDDCCYY) 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. This is a required field. Return as unprocessable if a date of service extends more than 1 day, and a valid "to" date is not present.

Note: You must choose the same date format for items 11b, 14, 16, 18, 19 and 24a

837P Professional Version 5010/5010A1:

- Loop ID 2400B
- Segment/Data Element:
  - DTP03

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Item 24B - Place of Service

Enter the appropriate place of service code(s) from the list provided in the" CMS IOM Pub 100-04, Chapter 26, Section 10.5 for codes and definitions. Identify the setting, using a place of service code, for each item used or service performed. This is a required field.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - o CLM05-1
- Loop ID 2400
- Segment/Data Element:
    - o SV105

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Item 24C - EMG

Medicare providers are not required to complete this item.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
  - SV109

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Item 24D - Procedures, Services, or Supplies

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 CMS-1500 claim form has the capacity 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. This is a required field.

The claim will be returned as unprocessable if an "unlisted procedure code" or a NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
    - SV101 (2-6)

Item 24E - Diagnosis Pointer

This is a required field. Enter the diagnosis code reference letter as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference letter per line item. When multiple services are performed, enter the primary reference letter for each service.

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.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
    - SV107 (1-4)

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Item 24F - $ Charges

Enter the charge for each listed service.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
  - SV102

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Item 24G - Days or Units

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.

NOTE: This field should contain an appropriate numerical value. The A/B MAC (B) should 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.

Refer to the CMS IOM Pub 100-04, Chapter 26, 10.4, for additional claims processing information.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
    - SV104

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Item 24H - EPSDT/Family Plan

Leave blank. Not required by Medicare.

837P Professional Version 5010/5010A1:

- Loop ID 2400
- Segment/Data Element:
    - o SV111
    - o SV112

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Item 24I - ID Qualifier

Leave blank, not required by Medicare.

837P Professional Version 5010/5010A1:

- Loop ID 2310B
- Segment/Data Element:
    - PRV02
    - REF01
- Loop ID 2420
- Segment/Data Element:
    - PRV02
    - REF01

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Item 24J - Rendering Provider ID#

Enter the rendering provider's NPI number in the lower 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 lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

837P Professional Version 5010/5010A1:

- Loop ID 2310B
- Segment/Data Element:
    - NM109
- Loop ID 2420A
- Segment/Data Element:
    - NM109

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Item 25 - Federal Tax ID Number

Enter the provider of service or supplier Federal Tax ID (Employer 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.

837P Professional Version 5010/5010A1:

- Loop ID 2010AA
- Segment/Data Element:
    - o REF01
    - o REF02

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Item 26 - Patient's Account No.

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.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - CLM01

Item 27 - Accept Assignment?

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 accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an 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 midwives, 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.

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837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
  - CLM07

Item 28 - Total Charge

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

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
  - CLM02

Item 29 - Amount Paid

Enter the total amount the patient paid on the covered services only.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
    - AMT02
- Loop ID 2320
- Segment/Data Element:
    - AMT02

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Item 30 - Rsvd for NUCC Use (previously Balance Due)

Leave blank. Not required by Medicare.

837P Professional Version 5010/5010A1:

- Loop ID N/A
- Segment/Data Element:
  - N/A

Item 31 - Signature of Physician or Supplier Including Degrees or Credentials

Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) 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.

837P Professional Version 5010/5010A1:

- Loop ID 2300
- Segment/Data Element:
  - CLM06

Item 32 - Signature of Physician or Supplier Including Degrees or Credentials

Only one 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.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate CMS-1500 claim form shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The A/B MAC (B) processing the foreign

claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

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.

Refer to the CMS IOM Pub 100-04, for additional claims processing information.

837P Professional Version 5010/5010A1:

- Loop ID 2310C
- Segment/Data Element:
    - NM103
    - N301
    - N401
    - N402
    - N403

Item 32a - NPI#

If required by Medicare claims processing policy, enter the NPI of the service facility.

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier on the claim on reference laboratory claims, even if the performing physician or supplier is enrolled in a different A/B MAC (B) jurisdiction. See Pub. 100-04, Chapter 1, §10.1.1 for more information regarding claims filing jurisdiction.

837P Professional Version 5010/5010A1:

- Loop ID 2310C
- Segment/Data Element:
    - NM109

Item 32b - Other ID#

Effective May 23, 2008, Item 32b is not to be reported.

837P Professional Version 5010/5010A1:

- Loop ID 2310C
- Segment/Data Element:

- REF01
- REF02

Item 33 - Billing Provider Info & Ph#

Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

837P Professional Version 5010/5010A1:

- Loop ID 2010AA
- Segment/Data Element:
    - NM103
    - NM104
    - NM105
    - NM107
    - N301
    - N401
    - N402
    - N403
    - PER04

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Item 33a - NPI#

Enter the NPI of the billing provider or group. This is a required field.

837P Professional Version 5010/5010A1:

- Loop ID 2010AA
- Segment/Data Element:
    - o NM109

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Item 33b - Other ID#

Item 33b is not generally reported. However, for some Medicare policies you may be instructed to use this item; direction as to how to use this item will be in the instructions you received regarding the specific policy, if applicable.

837P Professional Version 5010/5010A1:

- Loop ID 2000A
- Segment/Data Element:
    o PRV03
- Loop ID 2010AA
- Segment/Data Element:
    o REF01
    o REF02