

CMS-1500 Billing Guide for PROMISe™ Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)

Purpose of the document The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 Claim Form:

- **Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs) – Provider Type 08**

Document format This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
 - **Block Name** – Provides the block name as it appears on the claim.
 - **Block Code** – Lists a code that denotes how the claim block should be treated. They are:
 - M** – Indicates that the claim block must be completed.
 - A** – Indicates that the claim block must be completed, if applicable.
 - O** – Indicates that the claim block is optional.
 - LB** – Indicates that the claim block should be left blank.
 - *** – Indicates special instruction for block completion.
 - **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.
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CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms, you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents:**

1. Block 24F (\$Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is ninety-five dollars and you enter 95, your usual charge may be read as .95 cents.

Example #1: When completing Block 24F, enter your usual charges, without a decimal point. You must include the dollars and cents. If your usual charge is thirty-five dollars, enter:

| | |
|-----------|----|
| 24F | |
| \$CHARGES | |
| 35 | 00 |

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

| | |
|-------------|----|
| 29 | |
| Amount Paid | |
| 50 | 00 |

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

EPSDT Screens

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screens may bill using the CMS-1500 Claim Form or electronically using the 837P format.

FQHCs/RHCs may not bill for partial EPSDT Screens

Providers choosing to bill for EPSDT Screens via the CMS-1500 Claim Form must bill using Procedure Code T1015 with modifier EP in addition to all of the individual age-appropriate procedure codes from the Periodicity Schedule. These age-appropriate procedure codes must be entered on the CMS-1500 Claim Form in conjunction with the all-inclusive FQHC/RHC EPSDT visit, T1015 and Modifier EP. The age appropriate procedure codes from the Periodicity Schedule must also be billed with informational modifier EP and any other applicable modifiers.

Providers choosing to bill for EPSDT Screens via the CMS-1500 Claim Form must bill using all of the individual age-appropriate procedure codes, including immunizations, for a complete screen. Please consult the **Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix (Periodicity Schedule)** and the **Age Range Requirements for Screening Visits Desk Guide** as well as the **Recommended Childhood and Adolescent Immunization Schedules (Immunization Schedules)** for screening eligibility information and the services required to bill for a complete EPSDT Screen.

Note: The **Periodicity Schedule** and the **Immunization Schedules** are updated *periodically* and published in Medical Assistance Bulletins (MABs). Please use the most recent schedules when providing EPSDT Screens.

Please review the instructions in the billing guide for the following blocks when submitting a claim form for a complete EPSDT Screen:

FQHCs/RHCs must complete the CMS-1500 Claim Form as follows when billing for a **complete EPSDT Screen**:

- **Block 10d (Claim Codes (Designated by NUCC))** – This Block **MUST** be completed when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. Use the appropriate EPSDT Referral Code(s) when you refer a child to another practitioner as a result of the EPSDT Screen.
- **Block 21 (Diagnosis or Nature of Illness or Injury)** – The diagnosis (DX) code in block 21 must be **Z761, Z762, Z00121** or **Z00129** for an EPSDT Screen. When applicable, you may enter up to eleven additional DX codes.

Please note that you are **not required** to use immunization diagnosis codes.

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EPSDT Screens (Con't)

- **Block 24d** – Please list all of the required components of an EPSDT Screen, that were provided, in block 24d on lines 02 through 06. The EPSDT assessment code and modifier EP must be reported on the second claim line of block 24d. If more than six claim lines are necessary to report the components of a complete EPSDT Screen, **please use two claim forms**. If a second CMS-1500 Claim Form is necessary, use the second CMS-1500 Claim Form to report any additional procedure codes (e.g., immunizations).

For example, Block 24D would be completed as follows:

Block 24D (Procedures, Services, or Supplies [CPT/HCPCS & Modifier]) – Enter Procedure Code **T1015** in the first portion of this block, followed by Modifier **EP** in the second portion of this block on Claim Line 1.

| D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | |
|---|---|-------|----|
| CPT/HCPCS | MODIFIER | | |
| 1 | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">T1015</td> <td style="width: 50%; text-align: center;">EP</td> </tr> </table> | T1015 | EP |
| T1015 | EP | | |

Enter your usual charge in Block 24F (Charges) of Claim Line 1.

You must enter all of the **required components** of the complete EPSDT Screen that were performed on Claim Lines 2 through 6 in order to receive credit for performing a complete EPSDT Screen. This includes use of required modifiers, diagnosis codes and referral codes. If more than six claim lines are needed to report the **additional components** of the EPSDT Screen, you must complete a second CMS-1500 Claim Form.

Please Note: To insure correct documentation of a complete EPSDT Screen, you must list all of the required components of a complete EPSDT Screen on the claim where you report **T1015 EP** on Claim Line 1.

Use modifier **EP** on Claim Line 2 with the appropriate “Assessment” code for the Screening period.

Use referral code YD for all children age 3 and older for whom you have made the required referral to a dental home. The YD referral code is placed in Field 10D of the CMS 1500.

Use modifier **52 (EPSDT Screening Services/Components Not Completed)** with the CPT code for standard testing method for objective vision/hearing testing, anemia, dyslipidemia, lead and tuberculin testing not completed.

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**EPSDT
Screens
(Con't)**

Use modifier **90** (reference outside lab) with the CPT code when laboratory procedure(s) are performed by a party other than the treating or reporting physician.

The following provides an example of how you complete the CMS-1500 for a complete EPSDT Screen.

Example:

A 3 year old child comes into your clinic for his/her EPSDT Screen. As per the Periodicity Schedule, the **required components** for a 3 year EPSDT Screen are:

- A periodic preventative medicine evaluation (new patient – Procedure Code 99382) or reevaluation (established patient – Procedure Code 99392);
- Visual acuity screen (Procedure Code 99173)
- Hearing – Audio Screen or Pure tone-air only (Procedure Codes 92551 or 92552)
- Referral to a dental home.

Enter the required components of the EPSDT Screen, which were performed.

For example:

Claim Line 1, Block 24d – Enter T1015 EP

Claim Line 2, Block 24d – Enter 99392 EP

Claim Line 3, Block 24d – Enter 99173 EP

Claim Line 4, Block 24d – Enter 92551 EP

Block 10d, YD referral code

Utilize a second CMS-1500 Claim Form if more than six claim lines are required to report the components of the EPSDT Screen.

In this example, Block 24D, **line 3** would be completed as follows:

| D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | |
|---|-------------------|
| CPT/HCPCS | MODIFIER |
| 3 | 99173 EP |

Enter 0000 in Block 24F (Charges) on claims lines 2 through 6.

Utilize a second CMS-1500 Claim Form if more than six lines are required to report the components of the EPSDT Screen (for example: immunizations).

Please note you must add the YD, dental referral code to Block 10D for all children 3 years of age and older for whom you have provided the **required** dental referral.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

You must follow these instructions to complete the CMS-1500 Claim when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

| BlockNo. | Block Name | Block Code | Notes |
|----------|-----------------------------|------------|--|
| 1 | Type of Claim | M | Place an X in the Medicaid box. |
| 1a | Insured's ID Number | M | Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block. |
| 2 | Patient's Name | A | It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim. *This field is required when billing for newborns using the mother's beneficiary number. Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl. |
| 3 | Patient's Birthdate and Sex | A | Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an X in the appropriate box. *Same as the special instruction for Block 2. Enter the newborn's date of birth in an eight-digit format. |

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

| BlockNo. | Block Name | Block Code | Notes |
|----------|-----------------------------------|------------|--|
| 4 | Insured's Name | A | If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same; then the word SAME may be entered. If there is no other insurance other than MA, leave this block blank. |
| 5 | Patient's Address | O | Enter the patient's address. |
| 6 | Patient's Relationship to Insured | A | Check the appropriate box for the patient's relationship to the insured listed in Block 4. |
| 7 | Insured's Address | A | Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word SAME . Complete this block only when Block 4 is completed. |
| 8 | Reserved for NUCC Use | LB | Do not complete this block. |
| 9 | Other Insured's Name | A | If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word SAME . If the patient has MA coverage only, leave the block blank. |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|---|
| 9a | Other Insured's Policy or Group Number | A | This block identifies a secondary insurance other than MA, and the primary insurance listed in 11a–d. Enter the policy number <u>and</u> the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d , and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.) |
| 9b | Reserved for NUCC Use | LB | Do not complete this block. |
| 9c | Reserved for NUCC Use | LB | Do not complete this block. |
| 9d | Insurance Plan Name or Program Name | A | Enter the other insured's insurance plan name or program name. |
| 10a-10c | Is Patient's Condition Related To: | A | Complete the block by placing an X in the appropriate YES or NO box to indicate whether the patient's condition is related to employment, auto accident, or other accident (for example, liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's two-character postal code for the state in which the accident occurred in the PLACE block (for example, PA for Pennsylvania). |
| 10d | Claim Codes (Designated by NUCC) | A | <p>This Block MUST be completed when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. This block is used for Federal reporting purposes.</p> <p>This block has two uses:</p> <ol style="list-style-type: none"> 1) It is optional to enter the nine-digit social security number of the policyholder if the policyholder is not the beneficiary. 2) When billing for an EPSDT Screen, enter the applicable two-character EPSDT Referral Code for referrals made or needed as a result of the |

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

| BlockNo. | Block Name | Block Code | Notes |
|----------|---------------------------------------|------------|--|
| | | | <p>screen:</p> <p>Enter the applicable two-character EPSDT Referral Code in UPPERCASE / CAPITAL LETTERS.</p> <p>YM – Medical Referral</p> <p>YD – Dental Referral (a required component for all children 3 years of age and above)</p> <p>YV – Vision Referral</p> <p>YH – Hearing Referral</p> <p>YB – Behavioral Health Referral</p> <p>YO – Other Referral</p> <p>For a complete listing and explanation of EPSDT Referral Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</p> |
| 11 | Insured's Policy Group or FECA Number | A/A | Enter the policy number and group number of the primary insurance other than MA. |
| 11a | Insured's Date of Birth and Sex | A/A | Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03011978) and insured's gender if it is different than Block 3. |
| 11b | Other Claim ID (Designated by NUCC) | LB | Do not complete this block. |
| 11c | Insurance Plan Name or Program Name | A | List the name and address of the primary insurance listed in Block 11. |
| 11d | Is There Another Health Benefit Plan? | A | If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the YES box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource. |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|---|------------|--|
| 12 | Patient's or Authorized Person's Signature and Date | M/M | <p>The beneficiary's signature or the words Signature Exception must appear in this field.</p> <p>Also, enter the date of claim submission in an 8-digit MMDDCCYY format (for example, 03012004) with no slashes, hyphens, or dashes.)</p> <p>Note: Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.</p> |
| 13 | Insured's or Authorized Person's Signature | O | If completed, this block should contain the signature of the insured, if the insured is not the patient. |
| 14 | Date of Current Illness, Injury or Pregnancy (LMP) | O | If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03012004). |
| 15 | Other Date | O | If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03012002). |
| 16 | Dates Patient Unable to Work in Current Occupation | O | <p>If completed, enter the FROM and TO dates in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03012003), only if the patient is unable to work due to the current illness or injury.</p> <p>This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.</p> |
| 17 | Name of Referring Provider or Other Source | M | Enter the name and degree of the referring or prescribing practitioner, when applicable. |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|---|------------|--|
| 17a | I.D. Number of Referring Provider | M | <p>In the first portion of this block, enter a two-digit qualifier that indicates the type of ID:</p> <p>0B = License Number</p> <p>G2 = 13-digit Provider ID number (Legacy Number)</p> <p>In the second portion, enter the license number of the referring or prescribing practitioner named in Block 17 (for example, MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (for example, MD123456).</p> <p>If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.</p> |
| 17b | NPI # | M | Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source. |
| 18 | Hospitalization Dates Related to Current Services | LB | Do not complete this block. |
| 19 | Additional Claim Information (Designated by NUCC) | A/A | <p>This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "AT" followed by a two-digit number (for example, AT05).</p> <p>Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,).</p> <p>When using "AT05" indicating a Medicare payment, please remember to properly complete and attach the "Supplemental Medicare Attachment for Providers" form MA 539.</p> |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|------------|------------|---|
| | | | <p>When using “AT10” indicating a payment from a Commercial Insurance, please remember to properly complete and attach the "Supplemental Attachment for Commercial Insurance for Providers" form MA 538.</p> <p>Attachment Type Code “AT99” indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary’s number on the top left-hand corner of the page (for example, Enter AT26, AT99 if billing for newborns that have temporary eligibility under the mother’s beneficiary number. On the remarks sheet, include the mother’s full name, date of birth, and social security number.).</p> <p>If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment.</p> <p><i>For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</i></p> <p><i>For additional information on completing CMS-1500 Claim Form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.</i></p> |
| | | A | <p>Qualified Small Businesses</p> <p>Qualified small businesses must <u>always</u> enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes:</p> |

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| BlockNo. | Block Name | Block Code | Notes |
|---|--|------------|---|
| | | | “(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.” |
| <p>*Note: If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter AT05 in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.</p> | | | |
| 20 | Outside Lab | LB | Do not complete this block. |
| 21 | Diagnosis or Nature of Illness or Injury | M/A | <p>The ICD indicator (ICD Ind) is required. If a valid “9” or “0” indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete.</p> <p>For dates of service prior to October 1, 2015, enter the most specific ICD-9-CM code (indicator “9”); OR for dates of service on or after October 1, 2015, enter the ICD-10-CM code (indicator “0”) that describes the diagnosis.</p> <p>The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.</p> <p>When billing for complete EPSDT screening services, you must use one of the following Diagnosis Code’s: Z761, Z762, Z00121 or Z00.129</p> <p>You may enter up to a total of twelve diagnosis codes on the CMS 1500. An appropriate diagnosis code should be included for each referral.</p> <p>When reporting the administration of preventative pediatric immunizations, the appropriate CPT code is required along with diagnosis code Z23 (Need for prophylactic vaccination against bacterial, viral and other communicative diseases).</p> |
| 22 | Resubmission Code | A/A | <p>This block has two uses:</p> <ol style="list-style-type: none"> 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13- |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|----------------------------|------------|---|
| | | | <p>digit internal control number (ICN) of the ORIGINAL rejected claim in the right portion of this block (for example, 1103123523123).</p> <p>2) When submitting a claim adjustment for a previously approved claim. If submitting a claim adjustment, enter ADJ in the left portion of the block and the <u>LAST APPROVED</u> 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (for example, ADJ 1103123523123 01).</p> |
| 23 | Prior Authorization Number | A | <p>Enter the 10-digit prior authorization number when applicable.</p> <p>Refer to Section 7 of the CMS-1500 Provider Handbook for additional information regarding prior authorization for your specific provider type.</p> <p>Note: EPSDT Expanded Services, such as mobile therapy, behavioral health consultant, and therapeutic staff support services must be prior authorized and are billable by FQHCs/RHCs having special enrollment indicators on file with DHS and OMHSAS licensure. For more information, contact the Bureau of Fee-for-Service Programs.</p> |
| 24a | Date(s) of Service | M/M | <p>Enter the applicable date(s) of service.</p> <p>If the same service was provided on consecutive days, enter the first day of the service in the From column and the last day of service in the To column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.</p> |
| 24b | Place of Service | M | <p>Enter the 2-digit place of service code that indicates where the service was performed.</p> <p>RHCs:</p> |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|--|
| | | | <p>72 – Rural Health Clinic 12 – Home 21 – Inpatient Hospital 99 – Other (Community)</p> <p>FQHCs:</p> <p>50 – Federally Qualified Health Center 12 – Home 21 – Inpatient Hospital 99 – Other (Community)</p> <p>For specific provider type/specialty/procedure code/modifier/place of service combinations see the following bulletin:</p> <p><i>MA Program Fee Schedule Procedure Code Changes for FQHC's and Rural Health Clinics Bulletin.</i></p> |
| 24c | EMG | A | Enter 1 if the service provided was in response to an emergency, 2 if urgent. Otherwise, leave this item blank. |
| 24d | Procedures, Services, or Supplies (CPT/HCPCS & Modifier) | M/AAAA | <p>Enter Procedure Code T1015 in the first section of this block.</p> <p>In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to three additional informational modifiers, when applicable. If no pricing modifier is required, enter up to four additional / informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.</p> <p>Note: When billing for complete EPSDT Screens, <u>you are required</u> to enter Procedure Code T1015 and Modifier EP on the first claim line. For claim line 1, please refer to block 24f for instructions</p> |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|-----------------------|------------|---|
| | | | <p>on entering your usual charge. <u>You must enter all of the required age-appropriate procedure codes, with Modifier EP on claim lines 2-6.</u> Enter 0000 in Block 24F (\$Charges) for claim lines 2-6. If a second claim form is required, include only the additional components of the complete EPSDT screening on the second claim form.</p> |
| 24e | Diagnosis Pointer | M | <p>This block may contain up to four letters.</p> <p>Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21.</p> <p>If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis.</p> <p>Note: The primary diagnosis pointer must be entered first.</p> |
| 24f | \$Charges | M | <p>Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter 6500.</p> |
| 24g | Days or Units | M | <p>Enter the number of units or services provided.</p> |
| 24h | Family Planning or | A | <p>Enter the 2-digit visit code, if applicable. Visit codes are especially important if providing services that do not require copay (i.e., for a pregnant beneficiary or long term care resident.)</p> <p>When billing for EPSDT screening services, enter Visit Code 03.</p> <p><i>For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</i></p> |
| 24h | EPSDT | | |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|--|------------|--|
| 24i | ID Qualifier | A | Enter the two-digit ID Qualifier: G2 = 13-digit Provider ID Number (legacy #) |
| 24j (a) | Rendering Provider ID # | LB | Do not complete this block. |
| 24j (b) | NPI | LB | Do not complete this block. |
| 25 | Federal Tax I.D. Number | M | Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an X in the appropriate block. |
| 26 | Patient's Account Number | O | Use of this block is strongly recommended. It can contain up to 10 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect beneficiary number is listed. |
| 27 | Accept Assignment | LB | Do not complete this block. |
| 28 | Total Charge | LB | Do not complete this block. |
| 29 | Amount Paid | A | If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. Do not enter copay in this block. |
| 30 | Reserved for NUCC Use | LB | Do not complete this block. |
| 31 | Signature of Physician or Supplier Including Degree or Credentials | M/M | This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the |

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| BlockNo. | Block Name | Block Code | Notes |
|----------|---------------------------------------|------------|--|
| | | | claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (for example, 03012004). |
| 32 | Service Facility Location Information | LB | Do not complete this block. |
| 32a | | LB | Do not complete this block. |
| 32b | | LB | Do not complete this block. |
| 33 | Billing Provider Info & Ph.# | A/A & M/M | Enter the billing provider's name, address, and telephone number Do not use slashes, hyphens, or spaces. Note: If services are rendered in the patient's home or facility, enter the service location of the provider's main office. Note: RHCs/FQHCs <i>are not permitted to have payee arrangements.</i> FQHCs/RHCs must utilize the RHC's or FQHC's 9-digit provider number and 4-digit service location in this block. <i>FQHCs/RHCs are not permitted to utilize the practitioner's (i.e., physician, CRNP, or nurse) PA PROMISe™ provider number and service location to submit claims for payment.</i> |
| 33a | | M | Enter the 10-digit NPI number of the billing provider. |
| 33b | | M/A | Enter the 13-digit Group/Billing Provider ID number (Legacy #) |