Blue Care Network

Filling Out the CMS-1500 (08/05)

Note: Follow the guidelines stated in the "Guidelines for submitting claims" section of the *Claims* chapter in the *BCN Provider Manual*. Remember to secure all attachments per instructions.

Patient Information Section		
Field #	**Field Name**	**Instructions**
1	Type of coverage	Optional
1a	Insured's I.D. number	Enter the subscriber's complete contract number from the BCN card. Include all alpha and numeric characters.
2	Patient's name	Enter the patient's last name, followed by the first name and then a middle initial. Use a nickname only if the patient is listed on the contract that way.
3	Patient's birth date / sex	Enter the patient's birth date in a six-digit format. For example, enter May 3, 2007, as 050307. Enter an X in the appropriate gender box.
4	Insured's name	Enter the subscriber's last name, followed by the first name. Do not enter business names or insurance company names in this field.
5	Patient's address	Optional
6	Patient relationship to insured	Enter an X in the appropriate box. Do not use the box labeled Other. If the patient is a child or sponsored dependent, enter an X in the box labeled Child regardless of age.
7	Insured's address	Enter the subscriber's complete address and telephone number, including area code.
8	Patient status	Optional
9a–9d	Other insured's name / policy or group number / date of birth / employer's name or school name / insurance plan name or program name	• If billing services for a patient covered by a BCN contract only, leave blank. • If the patient may be covered by other insurance, see the coordination of benefits claim example in this chapter.
10a–10c	Is patient's condition related to employment? / auto accident? / other accident? /	• If patient's condition is related to a work injury or an auto or other accident: o Enter an X in the appropriate Yes box. o Enter an X in the No boxes of the other two types of accidents. o Enter the date of the accident in Field 14. • If patient's condition is not related to an accident or work-related injury, enter an X in all three boxes.
10d	Reserved for local use	Optional
11	Insured's policy group or FECA number	This field is optional. To complete this field, enter the subscriber's group number.
11a	Insured's date of birth / sex	Optional
11b	Insured's employer's name or school name	Optional
11c	Insurance plan name or program name	Optional
11d	Is there another health benefit plan?	Leave this field blank unless the patient is covered by another insurer. If another insurance is primary, see the coordination of benefits claim example in this chapter.

Blue Care Network

Filling Out the CMS-1500 (08/05)

Note: Follow the guidelines stated in the "Guidelines for submitting claims" section of the *Claims* chapter in the *BCN Provider Manual*. Remember to secure all attachments per instructions.

<table>
<tr><th colspan="3">Patient Information Section</th></tr>
<tr><th>Field #</th><th>Field Name</th><th>Instructions</th></tr>
<tr><td>12</td><td>Patient's or authorized person's signature</td><td>This field is optional. A signature in this field authorizes the release of medical records.</td></tr>
<tr><td>13</td><td>Insured's or authorized person's signature</td><td>Optional</td></tr>
<tr><td>14</td><td>Date of current illness or injury or pregnancy</td><td>Complete this field only for the following situations:
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>The service is related to end stage renal disease</td><td>Enter the date of the first maintenance dialysis or the date of the kidney transplant.</td></tr>
<tr><td>The service is related to an injury, initial treatment or a follow-up service</td><td>Enter the date of the injury.</td></tr>
<tr><td>The service is related to pregnancy</td><td>Enter the date of the last menstrual period.</td></tr>
<tr><td>The service is related to pregnancy and the provider is not able to determine the date of the last menstrual period</td><td>Enter the estimated date of conception.</td></tr>
</table></td></tr>
<tr><td>15</td><td>If patient has had same or similar illness, give first date</td><td>Optional</td></tr>
<tr><td>16</td><td>Dates patient unable to work in current occupation</td><td>Optional</td></tr>
<tr><td>17</td><td>Name of referring provider or other source</td><td>Enter the name of the referring physician.</td></tr>
<tr><td>17a</td><td>Other I.D. #</td><td>Leave blank.
NOTE: DO NOT add the servicing provider BCBSM license number here.</td></tr>
<tr><td>17b</td><td>NPI</td><td>Optional</td></tr>
<tr><td>18</td><td>Hospitalization dates related to current services</td><td>Complete this field only for inpatient services. Enter the admission date after From and the discharge date after To, using the six-digit format for each date.</td></tr>
<tr><td>19</td><td>Reserved for local use</td><td>Optional</td></tr>
<tr><td>20</td><td>Outside lab? / $ charges</td><td>Optional</td></tr>
<tr><td>21</td><td>Diagnosis or nature of illness or injury (relate items 1, 2, 3 and 4 to Field 24E by line)</td><td>Enter up to four ICD-9 diagnosis codes, each on its own numbered line. Use the highest level of specificity. Do not run the codes together on one line or use narrative descriptions of the diagnoses.</td></tr>
<tr><td>22</td><td>Medicaid resubmission code</td><td>Optional</td></tr>
<tr><td>23</td><td>Prior authorization number</td><td>Optional</td></tr>
</table>

Blue Care Network

Filling Out the CMS-1500 (08/05)

Note: Follow the guidelines stated in the "Guidelines for submitting claims" section of the *Claims* chapter in the *BCN Provider Manual*. Remember to secure all attachments per instructions.

Patient Information Section		
Field #	**Field Name**	**Instructions**
Shaded areas above Fields 24A through 24H		For BlueCaid claims only, enter information related to the NDC for pharmaceutical products administered by physicians (effective March 23, 2010).
24A	Date(s) of service	Use the six-digit format for the date of service. If the service is rendered on one day only, enter the same date of service in the From and To areas of the field. If billing for a span of dates, enter the first date in the From area and the last date in the To area.
24B	Place of service	Enter the appropriate number to describe the location at which care was provided. To find location codes, click on the following link: **Place of Service Codes**.
24C	EMG	Optional
24D	Procedures, services, or supplies	Enter the CPT* and HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service. The field accommodates up to four two-digit modifiers.
24E	Diagnosis pointer	Enter the one-digit diagnosis reference number as shown in Field 21, to relate the date of service to both the procedure performed and the applicable diagnosis. • Only numbers 1 through 4 are applicable. • Do not skip numbers.
24F	$ charges	Enter the original charge for the service being billed. If multiple services are being billed as a one-line item, enter the total amount for all services here. Do not include dollar signs, negative signs or any other nonnumeric characters.
24G	Days or units	Enter units, counts or quantities unless the description of the procedure code* references a quantity, such as per day, per cc, each additional, etc. If there is no quantity reference noted, enter a count of 1.
24H	EPSDT Family Plan	Optional
24I	I.D. qualifier	Optional
24J	Rendering provider I.D. #	Enter the individual NPI in the unshaded area of the field.
25	Federal Tax I.D. number	Enter the number issued for the practice by the Internal Revenue Service. This number is on the federal deposit coupon. Make sure that this number corresponds to the NPI.
26	Patient's account number	This field is optional. If an office case number has been assigned to the patient, enter it here. A maximum of 20 characters may be used. BCN will include this number on the payment voucher to assist with patient accounting.
27	Accept assignment?	Enter an X in the Yes box.
28	Total charge	Enter the total original charges for all services being billed.
29	Amount paid	Complete only if the patient has other insurance coverage. Enter the amount paid under the primary policy.

Filling Out the CMS-1500 (08/05)

Note: Follow the guidelines stated in the "Guidelines for submitting claims" section of the *Claims* chapter in the *BCN Provider Manual*. Remember to secure all attachments per instructions.

Patient Information Section		
Field #	**Field Name**	**Instructions**
30	Balance due	Complete only if the patient has other insurance coverage. Enter the balance due under the secondary policy.
31	Signature of physician or supplier	Include the servicing provider's signature or stamped reproduction along with all degrees or credentials.
32	Service facility location information	Enter the name and address of the hospital, facility or office site at which the services were performed.
32a	NPI	Optional
32b	Other I.D. #	Optional
33	Billing provider information and phone number	Enter the provider's billing name and complete address and phone number. **NOTE: This is the address to which BCN sends payment.**
33a	NPI	For the billing provider, enter the NPI as appropriate, either for the individual or for the group.
33b	Other I.D. #	Optional