wisconsin Medicaid update
and BadgerCare
December 2006 ● No. 2006-95
Wisconsin Medicaid and BadgerCare Information for Providers

New 1500 Health Insurance Claim Form and Supplemental Instructions

To:

- Ambulance Providers
- Ambulatory Surgery Centers
- Anesthesiologist Assistants
- Audiologists
- Case Management Providers
- Certified Registered Nurse Anesthetists
- Chiropractors
- Community Care Organizations
- Community Support Programs
- Comprehensive Community Service Providers
- Crisis Intervention Providers
- Day Treatment Providers
- Dentists
- Family Planning Clinics
- Federally Qualified Health Centers
- HealthCheck Providers
- Hearing Instrument Specialists
- Independent Labs
- Individual Medical Supply Providers
- Master's Level Psychotherapists
- Medical Equipment Vendors
- Mental Health/Substance Abuse Clinics
- Narcotic Treatment Service Providers
- Nurse Midwives
- Nurse Practitioners
- Nursing Homes
- Occupational Therapists
- Opticians
- Optometrists
- Pharmacies
- Physical Therapists
- Physician Assistants
- Physician Clinics
- Physicians
- Podiatrists
- Portable X-ray Providers
- Prenatal Care Coordination Providers
- Psychologists
- Rehabilitation Agencies
- Rural Health Clinics
- School-Based Services Providers
- Specialized Medical Vehicle Providers
- Speech and Hearing Clinics
- Speech-Language Pathologists
- Substance Abuse Counselors
- Therapy Groups
- HMOs and Other Managed Care Programs

Effective immediately, Wisconsin Medicaid is accepting the new 1500 Health Insurance Claim Form (dated 08/05), formerly referred to as the CMS 1500 claim form.

Providers submitting the new 1500 Health Insurance Claim Form (dated 08/05) to Wisconsin Medicaid should use their current service-specific CMS 1500 claim form instructions *and* the supplemental instructions in Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update*. Attachment 2 includes a sample 1500 Health Insurance Claim Form as a reference for providers.

New 1500 Claim Form Instructions

The following revisions have been made to the 1500 Claim Form:

- Element 17a is still used to indicate the referring provider's identification number, when applicable. Providers are required to indicate a provider identification qualifier in the first shaded field to the right of Element 17a. Qualifiers identify the type of identification number being indicated. Indicate the identification number itself in the second shaded field to the right of 17a.

Providers may use one of the following qualifiers for Element 17a.

Qualifier	Description
0B	State license number
1D	Medicaid provider number
1G	Universal Provider Identification Number (UPIN)

Providers should refer to their most current service-specific CMS 1500 claim form instructions to determine if they are required to indicate a referring provider number.

- Element 24C has been changed from "Type of Service" to "EMG" for providers to indicate emergency services. Providers are required to use a "Y" (instead of an "E") if a service was performed as an emergency. This element should be left blank if the procedure was not performed as an emergency.
- Element 24E has been changed from "Diagnosis Code" to "Diagnosis Pointer." Providers are still required to indicate the number (1 through 4) corresponding to the diagnosis code in Element 21 that is applicable to the service being billed.
- Element 24H is still used for family planning procedures; however, providers are now required to indicate a "Y" (instead of an "F") for each family planning procedure. This element should be left blank if the procedure was not a family planning procedure.
  Note: Providers should *not* use this element to indicate that a service was the result of a HealthCheck referral.
- The shaded areas of Elements 24I and 24J are used to identify the rendering (performing) provider. Indicate qualifier "1D" in the shaded area of Element 24I and indicate the rendering provider's Medicaid provider number in the shaded area of Element 24J. Providers should refer to their most current service-specific CMS 1500 claim form instructions to determine whether or not this element is required.
- Element 24K has been omitted.
- Element 32b has been added to indicate the facility's identification qualifier and Medicaid identification number. Providers should indicate qualifier "1D" followed by their Medicaid provider number. Providers should refer to their most current service-specific CMS 1500 claim form instructions to determine whether or not this element is required.
- Element 33b has been added to indicate the billing provider's identification qualifier and Medicaid identification number. Providers should indicate qualifier "1D" followed by the billing provider's Medicaid provider number. This element is required for *all* Medicaid providers.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Supplemental 1500 Health Insurance Claim Form Instructions

Providers are encouraged to use the following supplemental instructions, in addition to the current service-specific instructions, when submitting 1500 Health Insurance Claim Forms (dated 08/05) to Wisconsin Medicaid.

Note: Not all of the following elements are used by all providers. Providers should refer to their most current service-specific CMS 1500 claim form instructions to determine which elements are required.

Element 17a — Name of Referring Provider or Other Source (required, if applicable)
Enter a provider identification qualifier in the first shaded field to the right of Element 17a and the identification number itself in the second shaded field to the right of Element 17a to indicate a referring provider. Providers may use one of the following identifiers in this element:

- 0B — State license number
- 1D — Medicaid provider number
- 1G — Universal Provider Identification Number

Element 24C — EMG
Enter a "Y" for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

Element 24E — Diagnosis Pointer
Enter the number (1, 2, 3, or 4) that corresponds to the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code listed in Element 21.

Element 24H — EPSDT/Family Plan (required, if applicable)
Enter a "Y" for each family planning procedure. If family planning does not apply, leave this element blank.

Note: Providers should *not* use this element to indicate that a service is a result of a HealthCheck referral.

Element 24I — ID. Qual. (required, if applicable)
Enter the qualifier "1D" in the shaded area of this element if a rendering (performing) provider number will be indicated in Element 24J.

Element 24J — Rendering Provider ID. # (required, if applicable)
Enter the performing provider's Medicaid provider number in the shaded area of this element for each procedure, if that number is different than the billing provider number in Element 33b.

Element 32b — Service Facility Location Information (required, if applicable)
Enter the qualifier "1D" followed by the facility's Medicaid provider number.

Element 33b — Billing Provider Info & Ph # (ID. #) (required)
Enter the qualifier "1D" followed by the billing provider's Medicaid provider number.

ATTACHMENT 2
Sample 1500 Health Insurance Claim Form

1500

TEST VERSION – NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** SEX M F **X**

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

5. PATIENT'S ADDRESS (No., Street): **609 Willow St**

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: **Anytown** STATE: **WI**

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

CITY STATE

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX) XXX-XXXX**

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): **OI-P**

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. **1G X12345**

17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. L **XXX.XX** 3. L _____

2. L _____ 4. L _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM DD YY		**XX**		**XXXXX**	**XX**	**1**	**XXX XX**	**1.0**	**Y**	**1D**	**12345678**
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: **XXXXXXX**

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

28. TOTAL CHARGE: $ **XXX XX**

29. AMOUNT PAID: $ **XX XX**

30. BALANCE DUE: $ **XX XX**

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.)

I.M Auth **MM/DD/YY**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b. **1D11223344**

33. BILLING PROVIDER INFO & PH # ( )

I.M. Provider
1 W Williams St
Anytown WI 55555

a. NPI b. **1D87654321**

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

OMB APPROVAL PENDING