

# Medical Assistance Provider Bulletin

**Attention:** All Title XIX Community Care Organizations

**Subject:** New HCFA 1500 Claim Form

**Date:** March 13, 1992

**Code:** MAPB-092-006-O

Department of Health and Social Services, Division of Health,  
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

## TABLE OF CONTENTS

- I. INTRODUCTION
- II. NEW NATIONAL HCFA 1500 CLAIM FORM (12/90)
- III. PLACE OF SERVICE CODES
- IV. ATTACHMENTS

## I. INTRODUCTION

This Medical Assistance Provider Bulletin (MAPB) provides important information on the Wisconsin Medical Assistance Program's (WMAP) implementation of a new HCFA 1500 claim form. **It is important that providers review this information carefully and share it with their billing staff.** In order to consolidate the billing information previously sent to providers, this MAPB is being issued as a complete replacement to MAPB-087-005-O dated September 1, 1987.

**Providers should pay particular attention to the text and Attachments 1 and 2 of this MAPB for information on new billing procedures and policies.**

## II. NEW NATIONAL HCFA 1500 CLAIM FORM (12/90)

The Health Care Financing Administration (HCFA) has mandated that all state Medicaid programs use the revised National HCFA 1500 claim form (dated 12/90). All paper claims received by EDS from March 15, 1992, through May 1, 1992, may be submitted on either the current HCFA 1500 claim form (dated 1/84) or the new claim form.

**All claims, including the resubmission of any previously denied claims, received by EDS after May 1, 1992, must be submitted on the HCFA 1500 claim form dated 12/90. Claims received by EDS after May 1, 1992, on claim forms other than the HCFA 1500 (12/90) claim form, will be denied. Modified versions of the National HCFA 1500 claim form may also be denied.**

**Please allow ample mailing time to ensure that claims submitted on the current HCFA 1500 claim form are received at EDS by May 1, 1992.**

Crossover claims for Medicare Part B coinsurance and deductible allowed charges may be submitted on either the new or old HCFA 1500 claim form.

**There are no changes to the submission of electronic claims.**

A sample claim form and detailed claim form completion instructions are included in Attachments 1 and 2 of this MAPB. All claims received by EDS on the new HCFA 1500 claim form must be completed according to these instructions.

Community Care Organization providers should pay special attention to the following changes in the type of information required for completion of the claim form.

1. **Procedure code W6300 must be indicated in Element 24D of the claim form. The procedure code description is no longer required.**
2. **Place of service code "0" must be indicated in Element 24B of the claim form.**
3. **Type of service code "9" must be indicated in element 24C of the claim form.**

The National HCFA 1500 claim form is not provided by either the WMAP or EDS, but may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.  
P.O. Box 1109  
Madison, WI 53701  
(608) 257-6781  
1-800-362-9080

### III. PLACE OF SERVICE CODES

Until further notice, the WMAP will continue to require the single-digit place of service codes on the HCFA 1500 claim, not the two-digit place of service codes required by Medicare. Claims with Medicare Part B allowed charges that cross over to the WMAP from WPS will have the place of service codes automatically converted to single-digit codes for claims processing. However, paper crossover claims, as well as all paper and electronic claims submitted directly to the WMAP, must indicate the appropriate single-digit place of service code.

ATTACHMENTS  
CCO SERVICES

1. HCFA 1500 Claim Form Sample
2. HCFA 1500 Claim Form Completion Instructions

## ATTACHMENT 1

### NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR COMMUNITY CARE ORGANIZATIONS

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

#### **ELEMENT 1 - Program Block/Claim Sort Indicator**

Enter claim sort indicator "M" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

#### **ELEMENT 1a - INSURED'S LD. NUMBER**

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

#### **ELEMENT 2 - PATIENT'S NAME**

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

#### **ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX**

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

#### **ELEMENT 4 - INSURED'S NAME (not required)**

#### **ELEMENT 5 - PATIENT'S ADDRESS**

Enter the complete address of the recipient's place of residence.

#### **ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)**

#### **ELEMENT 7 - INSURED'S ADDRESS (not required)**

#### **ELEMENT 8 - PATIENT STATUS (not required)**

#### **ELEMENT 9 - OTHER INSURED'S NAME**

Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: <ul style="list-style-type: none"> <li>- noncovered service</li> <li>- applied to deductible or copayment</li> <li>- family planning services (if WPS-HMP only)</li> </ul>

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

**ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO** (not required)

**ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER**

This first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes **MUST** be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, this element may be left blank. If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

**ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE**

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

**ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY** (not required)

**ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS** (not required)

**ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** (not required)

**ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** (not required)

**ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN** (not required)

**ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** (not required)

**ELEMENT 19 - RESERVED FOR LOCAL USE** (not required)

**ELEMENT 20 - OUTSIDE LAB** (not required)

**ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

Enter diagnosis code V68.9 (unspecified encounter for administrative purposes). The diagnosis description is not required.

**ELEMENT 22 - MEDICAID RESUBMISSION** (not required)

**ELEMENT 23 - PRIOR AUTHORIZATION** (not required)

**ELEMENT 24A - DATE(S) OF SERVICE**

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing multiple dates of service for the same calendar month and on the same detail line, enter the month's first date of service in MM/DD/YY format in the "From" field. Enter the month's last date of service in the "To" field in DD format.

**ELEMENT 24B - PLACE OF SERVICE**

Enter the single-digit place of service code "0" for each service.

**ELEMENT 24C - TYPE OF SERVICE CODE**

Enter the single-digit type of service code "9" for each service.

**ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES**

Enter the five-character procedure code W6300 (CCO Administrative Fee).

**ELEMENT 24E - DIAGNOSIS CODE**

Enter "1" to refer to the diagnosis indicated in element 21.

**ELEMENT 24F - CHARGES**

Enter the total charge for each line.

**ELEMENT 24G - DAYS OR UNITS**

Enter the total number of days being billed for each line.

**ELEMENT 24H - EPSDT/FAMILY PLANNING** (not required)

**ELEMENT 24I - EMG**

Enter an "E" for each procedure performed as an emergency.

**ELEMENT 24J - COB** (not required)

**ELEMENT 24K - RESERVED FOR LOCAL USE**

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

**ELEMENT 25 - FEDERAL TAX ID NUMBER** (not required)

**ELEMENT 26 - PATIENT'S ACCOUNT NO.**

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

**ELEMENT 27 - ACCEPT ASSIGNMENT**

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

**ELEMENT 28 - TOTAL CHARGE**

Enter the total charges for this claim.

**ELEMENT 29 - AMOUNT PAID**

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

**ELEMENT 30 - BALANCE DUE**

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

**ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER**

The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

**ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)**

**ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #**

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

ATTACHMENT 2

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**HEALTH INSURANCE CLAIM FORM**

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	12. 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 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street)
CITY Anytown, WI	STATE WI	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-D	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER M-8 a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME
a. OTHER INSURED'S POLICY OR GROUP NUMBER	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # 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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V68.9 2. _____ 3. _____ 4. _____	23. PRIOR AUTHORIZATION NUMBER	24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE MM DD YY MM DD YY CPT/HCPCS MODIFIER 1 02 01 92 29 0 9 W6300 1 XX XX 29 2 3 4 5 6 spenddown XX.XX
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 1234JED	27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO
28. TOTAL CHARGE \$ XX XX	29. AMOUNT PAID \$ 0 00	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. Authorized MM/DD/YY SIGNED _____ DATE _____	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# _____ GRP# _____	