November 2015

ND Health Enterprise MMIS CMS 1500 Claim Form Instructions

These instructions address the North Dakota Health Enterprise MMIS paper claim requirements.

You must be an enrolled ND Medicaid provider to submit a claim. If you are not an enrolled provider, you can apply at: https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment.

Enrollment instructions, updates, billing manuals, and companion guides are available online at http://www.nd.gov/dhs/info/mmis.html.

Questions

If you have any questions, please call the ND Health Enterprise MMIS Call Center at 1-877-328-7098.

Claims Mailing Address

ND Department of Human
Services Medical Services Division
Department 325
600 East Boulevard Ave
Bismarck, ND 58505-0250

Field Requirement Definitions

Required

Fields marked **Required** in the claim form instructions are required on all paper claim submissions. The claim will be denied if a **Required** field is incomplete.

Not Required

Fields marked Not Required are not used in processing the claim. Providers are free to populate the field if desired.

Recommended

Fields marked Recommended are not required, but will be returned with the provider's remittance advice if supplied on the claim. For example, if the provider's in-house patient account number is provided, it will be returned on the remittance advice, thereby allowing billing staff to cross reference the claim with the provider's records.

Situational

Fields marked *Situational* are required when they apply to the claim.

Field	Requirement	Field Name and Description
1	Not Required	Indicate the type of health insurance coverage applicable to this claim
1a	**Required**	Insured's ID Number: Enter the member's 9-digit member ID.
2	**Required**	Patient's name: Enter the member's full last name, first name and middle initial.
3	**Required**	Patient's Birth Date, Sex: Enter an X in the correct box to indicate the member's gender.
4	Not Required	Insured's Name
5	Not Required	Patient's Address, City, State, Zip Code, Telephone Number
6	Not Required	Patient Relationship to Insured
7	Not Required	Insured's Address, City, State, Zip Code, Telephone Number
8	Not Required	Reserved for NUCC use
9	Not Required	Other insured's name
9a	*Situational*	Other Insured's Policy or Group Number: • If the member has TPL with Medicare coverage, enter the member's Medicare number. • If the member has TPL with commercial coverage, enter the member's identifier with their primary carrier.
9b	Not Required	Reserved for NUCC Use
9c	Not Required	Reserved for NUCC Use
9d	*Situational*	Insurance Plan Name or Program Name: • **Required if** the member has Medicare coverage, enter the word **Medicare**. • **Required if** the member has TPL with commercial coverage, enter the name of the primary carrier.
10a-10c	*Situational*	Is Patient's Condition Related To: If the member's condition is a result of a work-related circumstance/occurrence, an automobile accident or other type of accident, check YES on the appropriate line.
10d	Not Required	Reserved for Local Use
11	Not Required	Insured's Policy Group or FECA Number: • If the member has two forms of TPL with commercial coverage, enter the policy number of the secondary carrier. • If the member's secondary carrier is Medicare, enter the policy number of the primary carrier. (Medicare information is entered in Fields 9–9d).
11a	Not Required	Insured's Date of Birth and Sex
11b	Not Required	Other Claim ID (Designated by NUCC)

11c	Not Required	Insurance Plan Name or Program Name: • If the member has two forms of TPL with commercial coverage, enter the name of the secondary carrier. • If the member's secondary carrier is Medicare, enter the name of the primary carrier. (Medicare information is entered in Fields 9–9d).
11d	*Situational*	Is There Another Health Benefit Plan?: If yes, complete items 9, 9a and 9d.
12	Not Required	Patient's or Authorized Person's Signature
13	Not Required	Insured's or Authorized Person's Signature
14	*Situational*	Date of Current Illness, Injury, or Pregnancy: Enter the date if any of the following are applicable: • For services related to an illness, enter the date that the first symptoms occurred. • For injury-related services, enter the date of the accident. • For chiropractic services, enter the date of the first treatment. • For pregnancy-related services, enter the date of the first day of the woman's last menstrual period (LMP).
15	Not Required	Other Date
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	*Situational*	Enter the Provider Role qualifier and the Provider Name
17a	*Situational*	Enter the Taxonomy affiliated with the Provider listed in Field 17 on paper claims
17b	*Situational*	Enter the NPI of the provider listed in Field 17.
18	Not Required	Hospitalization Dates Related to Current Services
19	*Situational*	Additional Claim Information (Designated by NUCC): Laboratory services: Enter the provider's CLIA number.
20	Not Required	Outside Lab Charges
21	**Required**	Diagnosis or Nature of Illness or Injury: Enter the ICD Indicator and up to 12 diagnosis codes in the spaces indicated A through L. Enter the codes across each Line, not down.
22	*Situational*	Resubmission Code: Complete this field to replace or void a previously paid claim. Otherwise, leave this field blank. See Void and Replace information on page 9.
23	*Situational*	Prior Authorization Number: Enter the 12-digit authorization number if you obtained authorization for an item on this claim. Enter only one authorization number per claim form. Complete additional forms if needed.
24a	**Required**	Date(s) of Service: In the bottom, white half of the claim Line, enter the beginning (From) and end (To) date of service. If a service was provided on one day only, enter the same date twice.

24b	**Required**	Place of Service: In the bottom, white half of the claim Line, enter the most appropriate Place of Service Code.
24c	Not Required	EMG
24d	**Required**	Procedures, Services or Supplies CPT/HCPCS modifier: CPT/HCPCS Code: In the bottom, white half of the claim Line, enter one CPT or one HCPCS code and up to 4 modifiers.
24e	**Required**	Diagnosis Pointer: In the bottom, white half of the claim Line, enter the diagnosis pointer on this claim line for diagnosis codes in Field 21.
24f	**Required**	$ Charges: In the bottom, white half of the claim Line, enter your usual and customary charge for the CPT/HCPCS on this claim line.
24g	**Required**	Days or Units: In the bottom, white half of the claim Line, enter the number of days or units being billed.
24h	*Situational*	EPSDT/Family Plan: For providers that bill Family Planning services: In the bottom, white half of the claim Line, enter Y if services were Family Planning and N if they were not.
24i	Recommended	ID Qualifier: Enter ZZ in the top shaded half of the claim Line.
24j	*Situational*	Rendering Provider ID#: • In the top, shaded half of the claim Line, enter the provider's taxonomy code. • In the bottom, white half of the claim Line, enter the provider's NPI.
25	Not Required	Federal Tax ID Number: Enter the billing provider's Social Security Number (SSN) or Employer Identification Number (EIN). Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	Recommended	Patient's Account Number: Enter the member's unique control number assigned by the provider (internal patient account number).
27	Not Required	Accept Assignment
28	**Required**	Total Charge: Add all amounts in column 24F. Enter the total in this Field.
29	*Situational*	Amount Paid: Enter the exact amount paid by all other carriers if the member has TPL.
30	Not Required	Reserved for NUCC Use
31	**Required**	Signature of Physician or Supplier: The billing provider or authorized representative must sign and date this field. Original, rubber stamp, and electronic signatures are accepted.
32	Not Required	Service Facility Location Information: Enter the name and full address of the location where service was rendered.

32a	Not Required	NPI #
32b	Not Required	Other ID #
33	**Required**	Billing Provider Info and Phone #: Enter the billing provider's name and phone number.
33a	**Required**	Enter the billing provider's NPI.
33b	**Required**	Enter the billing provider's Taxonomy. Example: 208D00000X

Replacing a Claim

A claim replacement may be submitted to modify a previously paid claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:

- Field 22: Enter the Resubmission Code of 7 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).
    - If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
    - If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

  Example:

  Legacy ICN: 1015015320010

  Replaced Legacy ICN: 10**20**15015320010

Voiding a Claim

Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:

- Field 22: Enter the Resubmission Code of 8 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).
    - If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
    - If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

  Example:

  Legacy ICN: 1015015320010

  Replaced Legacy ICN: 10**20**15015320010

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

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

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

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 ________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. 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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SAMPLE

Revision History

Section	Topic	Location	Revision Date
Intro	Updated contact history	Page 1	10/26/15
17a	Remove reference to qualifier ZZ	Page 4	10/26/15
24i	Change from Not Required to Recommended	Page 5	10/26/15
33a	Remove reference to qualifier code of XX	Page 6	10/26/15
33b	Remove reference to qualifier code of ZZ and remove reference to ZZ on example	Page 6	10/26/15
9d	Added 'Required if' after each bullet	Page 3	11/18/15