



BlueCross BlueShield of Texas

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A Guide for Completing the

CMS-1500 Form

Version 08/05

Blue Cross and Blue Shield of Texas offers this guide to help you complete the CMS-1500 (08/05) form for your patients with BlueShield coverage.

Thank you for helping us to process your claims efficiently and accurately.

TO ORDER CMS-1500 (08/05) FORMS:

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Blue Cross and Blue Shield of Texas

P.O. Box 660044

Dallas, TX 75266-0044

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLKLUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) R
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) R		4. INSURED'S NAME (Last Name, First Name, Middle Initial) R
3. PATIENT'S BIRTH DATE (MM DD) R SEX M <input type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) R
5. PATIENT'S ADDRESS (No., Street) R		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> R
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> B
ZIP CODE	TELEPHONE (Include Area Code) ()	Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) C		11. INSURED'S POLICY GROUP OR FECA NUMBER R
a. OTHER INSURED'S POLICY OR GROUP NUMBER C		a. INSURED'S DATE OF BIRTH (MM DD YY) B SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) C M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME B
c. EMPLOYER'S NAME OR SCHOOL NAME C		c. INSURANCE PLAN NAME OR PROGRAM NAME R
d. INSURANCE PLAN NAME OR PROGRAM NAME C		10d. RESERVED FOR LOCAL USE C

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. **R**

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. **R**

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) C	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE B	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 R	17a. NR	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM DD YY) TO (MM DD YY) B
19. RESERVED FOR LOCAL USE C	17b. NPI C	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO B \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) R		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. _____ 3. _____		23. PRIOR AUTHORIZATION NUMBER C
2. _____ 4. _____		

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. EPSTDJ Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
R	R		R	R	R	R		NR	NR
								NPI	C
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER R SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. B	27. ACCEPT ASSIGNMENT? (For gov. is, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO C	28. TOTAL CHARGE \$ R	29. AMOUNT PAID \$ C	30. BALANCE DUE \$ B
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.) R		32. SERVICE FACILITY LOCATION INFORMATION C		33. BILLING PROVIDER INFO & PH # () R	
SIGNED _____ DATE _____		a. C	b. NR	a. R	b. NR

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

KEY

- R** TDI REQUIREMENT
- C** TDI CONDITIONAL ELEMENT
- B** BCBSTX REQUESTED ELEMENT
- NR** NOT REQUIRED/NOT USED

1. **Type of Health Insurance ^B**
Claim Editing Indicator—For services being billed to Blue Shield of Texas, place “X” in the box marked (GROUP HEALTH PLAN). If the member has HMO or Commercial Insurance, select (OTHER).

- 1a. **INSURED ID NUMBER ^R**
Enter the Identification number found on the insured’s BCBS ID card.

2. **PATIENT’S NAME ^R** Enter patient’s Last name, First name, Middle initial, patient generation, (i.e., Jr., Sr.), if applicable.

3. **PATIENT’S BIRTH DATE/SEX ^R**
Enter patient’s date of birth using an eight-digit date format (MM/DD/CCYY). Enter “X” in appropriate box to indicate patient’s sex.

4. **INSURED’S NAME ^R** Enter insured’s Last name, First name, Middle initial, patient generation, (i.e., Jr., Sr.), if applicable.

5. **PATIENT’S ADDRESS/TELEPHONE NUMBER ^R**
Enter patient’s permanent mailing address and telephone number. Street, City, State, Zip Code.

6. **PATIENT’S RELATIONSHIP TO THE INSURED ^R**
Place an “X” in the appropriate box for patient’s relationship to the insured.

7. **INSURED’S ADDRESS ^R**
Enter insured’s Street, City, State, Zip Code (complete if different than patient’s address).

8. **PATIENT STATUS ^B**
Place “X” in the appropriate box for patient’s marital, student and employment status.

9. **OTHER INSURED’S NAME ^C**
Enter other insured’s Last name, First name, Middle initial, if applicable. When the patient has other insurance coverage complete 9 through 9d. This information is necessary to coordinate benefits with other insurance companies.

- 9a. **OTHER INSURED’S POLICY OR GROUP NUMBER ^C**
Enter group number, group name, Medigap Policy Number, Employee ID number of other insured.

- 9b. **OTHER INSURED’S DATE OF BIRTH AND SEX ^C**
Other Insured’s Date of Birth, Sex Enter other insured’s date of birth using an eight-digit date format (MM/DD/CCYY). Enter “X” in appropriate box to indicate insured’s sex.

- 9c. **EMPLOYER’S NAME OR SCHOOL NAME ^C**
Enter other insured’s employer.

- 9d. **INSURANCE PLAN NAME OR PROGRAM NAME ^C**
Enter other insured’s group name.

- 10a-d. **IS PATIENT’S CONDITION RELATED TO:**

- 10a. **EMPLOYMENT:** For Employment Related Indicator, place an “X” in the appropriate box. ^R

- 10b. **AUTO ACCIDENT:** For Auto Accident Related Indicator, place an “X” in the appropriate box. If yes, enter the state in which the accident occurred. Use two-character abbreviation, i.e. TX. ^R

- 10c. **OTHER ACCIDENT:** For Other Accident Related Indicator, place an “X” in the appropriate box. ^R

- 10d. **RESERVED FOR LOCAL USE: ^C**
If claim is a duplicate claim, a “D” is required. If claim is a corrected claim, a “C” is required.
(11 thru 11d, refer to BCBS subscriber coverage)

11. **INSURED’S POLICY GROUP OR FECA NUMBER ^R**
Enter the Group number from the subscriber’s Blue Cross and Blue Shield Card.

- 11a. **INSURED’S DATE OF BIRTH, SEX ^B**
Enter insured’s date of birth using an eight-digit date format (MM/DD/CCYY). Enter “X” in appropriate box to indicate patient’s sex.

- 11b. **EMPLOYER’S NAME OR SCHOOL NAME ^B**
Enter insured’s employer or school.

- 11c. **INSURANCE PLAN NAME OR PROGRAM NAME ^R**
Enter name of insured’s insurance plan, include name of state, i.e., Blue Shield of TX.

- 11d. **IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN ^R**
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.

12. **PATIENT OR AUTHORIZED PERSON’S SIGNATURE ^R**
Patient’s or Authorized Person’s Signature required but may indicate “Signature on File”.

13. **INSURED’S OR AUTHORIZED PERSON’S SIGNATURE ^R**
Insured’s or Authorized Person’s Signature required but may indicate “Signature on File”.

14. **DATE OF CURRENT ILLNESS, INJURY, PREGNANCY ^C**
Enter date using an eight-digit date format MM/DD/CCYY).

15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE ^B**
Enter date using an eight-digit date format MM/DD/CCYY).

16. **DATES PATIENT UNABLE TO WORK: FROM DATE, TO DATE**
Enter date using an eight-digit date format MM/DD/CCYY), if applicable.

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE ^R**
Enter name (First, MI, Last name) and credentials of referring, ordering or supervising provider.
Note: If none, enter “self-referral” or “none.”

- 17a. **OTHER ID# ^{NR}**
Not required, reserved for taxonomy code (preceded by “ZZ” qualifier).

- 17b. **NPI # ^C**
Enter the 10-digit NPI number of the referring, ordering or supervising provider.

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICE: FROM DATE, TO DATE ^B**
Enter inpatient hospital admission date and discharge date using an eight-digit date format MM/DD/CCYY).

19. **RESERVED FOR LOCAL USE ^C**
Description for NOC or NDC required, if applicable.

20. **OUTSIDE LAB/CHARGES ^B**
If laboratory work was performed outside the physician’s office, place an “X” in “yes box and enter the total charges.

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ^R**
Enter the ICD-9-CM Codes. The primary diagnosis should be first, followed by other diagnoses.
Enter up to 4 ICD-9-CM Codes.

22. **MEDICAID RESUBMISSION CODE**
Medicaid Resubmission Code.

23. **PRIOR AUTHORIZATION NUMBER ^C**
Required only if a Preauthorization or Verification is done.

24. **SHADED AREA – SUPPLEMENTAL INFORMATION –**
The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee’s Web site at www.nucc.org.

- 24a. **DATE(S) OF SERVICE: FROM, TO ^R**
Enter the dates of service using an eight-digit date format MM/DD/CCYY).

- 24b. **PLACE OF SERVICE ^R**
Enter the appropriate 2 digit Place of Service code.

- 24c. **EMG**
Emergency Indicator – Y for “Yes”, leave blank if “No.”

- 24d. **PROCEDURES, SERVICES, OR SUPPLIES ^R**
Enter the CPT or HCPCS code for the procedures, service or suppliers and enter a modifier, if applicable.

- 24e. **DIAGNOSIS CODE ^R**
Enter one ICD-9-CM diagnosis code for each procedure performed. Enter only one code per line of service.

- 24f. **CHARGES ^R**
Enter charge for each line of service. This should be original charge not the balance due or patient liability. Do not include discounts.

- 24g. **DAYS OR UNITS ^R**
Enter number of days or units.

- 24h. **EPSTD FAMILY PLAN**
For Early & Periodic Screening, Diagnosis and Treatment. Shaded area qualifiers: S2 – Under Treatment, ST–New Service Requested.

- 24i. **ID QUALIFIER - SHADED FIELD ^{NR}**
Not required, reserved for taxonomy code qualifier, “ZZ.”

- 24j. **RENDERING PROVIDER ID. #**
SHADED FIELD ^{NR}
Not required, reserved for taxonomy code.
NON-SHADED FIELD ^C
Enter performing provider 10-digit NPI number.

25. **FEDERAL TAX I.D. NUMBER ^R**
Enter the provider of service’s Federal Tax ID number. Place an “X” in the appropriate box or SSN or EIN.

26. **PATIENT ACCOUNT NUMBER ^B**
Enter account number assigned to the patient, if applicable.

27. **ACCEPT ASSIGNMENT ^C**
Enter “Yes” if the provider should be paid or enter “No” if the patient should be paid.

28. **TOTAL CHARGE ^R**
Enter total charges (total of all charges in 24f).

29. **AMOUNT PAID ^C**
Enter any amount paid by the patient.

30. **BALANCE DUE ^B**
Enter the difference, if any, between the total charge and amount paid.

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER ^R**
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated using an eight-digit date format (MM/DD/CCYY).

32. **SERVICE FACILITY LOCATION ^C**
Enter location where services were rendered. According to Texas state law, this field is required if the services were performed somewhere other than the patient’s home.

- 32a. **NPI # ^C**
Enter the 10-digit NPI number of the service facility location.

- 32b. **PROVIDER ID # ^{NR}**
Not required, reserved for taxonomy code (preceded by “ZZ” qualifier).

33. **BILLING PROVIDER INFO & PHONE # ^R**
Enter provider’s or supplier’s information that is requesting to be paid for services rendered.

- 33a. **NPI # ^R**
Enter the 10-digit NPI number of the billing provider.

- 33b. **PROVIDER ID # ^{NR}**
Not required, reserved for taxonomy code (preceded by “ZZ” qualifier).

Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17-19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

Note: For more information on Place of Service Codes, see the National Uniform Claim Committee's Web site at www.nucc.org.

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

- 7 Anesthesia information
- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)
- VP Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard
- OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
- CTR Contract rate

For additional information for reporting NDC units, see the National Uniform Claim Committee's Web site at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, zip code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in the BCBSTX's system just the way they leave your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

To obtain more information on electronic claim filing, call (800) 746-4614 or log on to www.bcbstx.com.