CLAIM COMPLETION INSTRUCTIONS

Use these instructions for completing this form. The HCFA-1500 has space for physicians and suppliers to provide information on other health insurance. Use this information to determine whether the Medicare patient has other coverage which must be billed prior to Medicare payment, or whether there is a Medigap policy under which payments are made to a participating physician or supplier.

ITEMS 1-13-PATIENT AND INSURED INFORMATION

Item 1. Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.
Item 1a. Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.
Item 2. Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.
Item 3. Enter the patient's eight-digit birth date (MMDDCCYY) and sex.
Item 4. If there is insurance primary to Medicare, either through the patient's or spouse's employer or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.
Item 5. Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.
Item 6. Check the appropriate box for patient's relationship to insured when item 4 is completed.
Item 7. Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 & 11 are completed.
Item 8. Check the appropriate box for the patient's marital status and whether employed or a student.
Item 9 thru 9d. Leave blank.
Items 10a thru 10c. Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.
Item 10d. Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.
Item 11. THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.
If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a-11c.
If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.
If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g. - insured retired), enter the word "NONE" and proceed to item 11b.
Insurance Primary to Medicare-Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
  - Working Aged
  - Disability-(Large Group Health Plan); and
  - End Stage Renal Disease.
- No Fault and/or Other Liability;
- Work-Related Illness/Injury;
  - Workers' Compensation;
  - Black Lung; and
  - Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.
Item 11a. Enter the insured's eight-digit birth date (MMDDCCYY) and sex if different from Item 3.
Item 11b. Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter the eight-digit retirement date (MMDDCCYY) preceded by the word "RETIRED."
Item 11c. Enter the complete insurance plan or program name, e.g., Blue Shield of (State). If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.
Item 11d. Leave blank. Not required by Medicare.
Item 12. The patient or authorized representative must sign and enter the eight-digit date (MMDDCCYY). If the patient is physically or mentally unable to sign, a representative specified in §3008 may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the

representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.
The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the physician or supplier, when the physician/supplier accepts assignment on the claim.
Signature by Mark (X). When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.
Item 13. The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating physician/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

ITEMS 14-33-PHYSICIAN OR SUPPLIER INFORMATION

Item 14. Enter eight-digit date (MMDDCCYY) of current illness, injury, or pregnancy. For chiropractic services, enter the eight-digit date (MMDDCCYY) of the initiation of the course of treatment and enter the eight-digit X-ray date (MMDDCCYY) in item 19.
Item 15. Leave blank. Not required by Medicare.
Item 16. Enter eight-digit dates (MMDDCCYY) the patient is employed and unable to work in current occupation. An entry in this field may indicate employment related insurance coverage.
Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.
Referring Physician: A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
Ordering Physician: A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Social Security Act. All claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services;
- Diagnostic radiology services;
- Consultative services; and
- Durable medical equipment.

Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form.
Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form.
Item 17a. Enter the HCFA assigned (UPIN) of the referring/ordering physician listed in item 17. The first position of the UPIN must be alpha, the second and third alpha or numeric, and the last three, numeric. When a claim involves multiple referring and/or ordering physicians, a separate HCFA-1500 must be used for each ordering/referring physician.
Item 18. Enter the eight-digit date (MMDDCCYY) when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
Item 19. Enter the eight-digit date (MMDDCCYY) the patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist, psychotherapist, or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file. (See §2206.1.)
Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.
Enter whether a "pump" or "reservoir" is used when HCPCS codes 63750 and/or 63780 are used.
Enter the statement "Attending physician, not hospice employee" when a physician renders services to a hospice patient but the hospice in which the patient resides does not employ the physician.
Item 20. Leave blank.
Item 21. Enter the patient's diagnosis/condition. The physician must use the ICD-9-CM code number. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.
Item 22. Leave blank. Not required by Medicare.
Item 23. Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval.
Item 24a. Enter the eight-digit date (MMDDCCYY) for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G.
Item 24b. Enter the appropriate place of service code from the list provided. Identify the location where the item is used or the service is performed.

Place of service codes and definitions are as follows: (The place of service should be shown as the place where the item, equipment or supply will be used.)

12 Patient's Home-Location, other than a hospital or other facility, where the patient receives care in a private residence.

21 Inpatient Hospital-A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians admitted for a variety of medical conditions. (Valid for PEN claims only.)

31 Skilled Nursing Facility-A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility-A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons or, on a regular basis, health-related services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility-A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice-A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

54 Intermediate Care Facility/Mentally Retarded-A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility-A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center-A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

61 Comprehensive Inpatient Rehabilitation Facility-A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.
Item 24c. Leave blank.

Item 24d. Enter the procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
Enter the specific procedure code without a narrative description. However, when you enter an unlisted procedure code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.
Item 24e. Enter the diagnosis code reference number as shown in item 21, to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; either a 1, or a 2, or a 3, or a 4.
Item 24f. Leave blank.
Item 24g. Enter the number of days or units. This field is most commonly used for multiple visits or units of supplies. If only one service is performed, the numeral 1 must be entered.
Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures). When multiple services are provided, enter the actual number provided.
Item 24h. Leave blank. Not required by Medicare.
Item 24i. Leave blank. Not required by Medicare.
Item 24j. Leave blank. Not required by Medicare.
Item 24k. Enter the carrier assigned Provider Identification Number (PIN) when the performing physician/supplier is a member of a group practice.
When several different physicians or suppliers within a group are billing on the same HCFA-1500 form, show the individual PIN in the corresponding line item.
Item 25. Enter your physician/supplier Federal Tax I.D. (Employer Identification Number) or Social Security Number. The participating physician/supplier Federal Tax I.D. Number is required for a mandated Medigap transfer.
Item 26. Enter the patient's account number assigned by the physician's/supplier's accounting system. This is a physician/supplier optional field to enhance patient identification.
Item 27. Leave blank.
Item 28. Leave blank
Item 29. Enter the total amount the patient paid on the covered services only.
Item 30. Leave blank. Not required by Medicare.
Item 31. Leave blank.
Item 32. Leave blank.
Item 33. Leave blank.