# HOW TO COMPLETE THE CMS 1500 CLAIM FORM

***DHS CHOICES Waiver Providers***
***Effective June 1, 2023***

Rev. 06/14/2023

The following is a step-by-step explanation of how to prepare the health insurance claim form, CMS 1500. Failure to properly complete MANDATORY requirements will cause the claim to be denied by South Dakota Medicaid. If submitting paper claims, please refer to http://dss.sd.gov/medicaid/ocr.aspx for claim form requirements.

**BLOCK 1A INSURED'S ID NO.** ***(MANDATORY)***
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.

**BLOCK 2 PATIENT'S NAME** ***(MANDATORY)***
Enter the recipient's last name, first name and middle initial.

**BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** ***(MANDATORY)***

1. Enter 0 for the ICD-10-CM indicator.
2. Enter the codes on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code.

**BLOCK 22 RESUBMISSION CODE**

1. Enter a 7 for an Adjustment; or an 8 for a Void.
2. List the original reference number found on your remittance advice. This number will always be 14 digits.

   Note: You cannot void or adjust one line on the claim. The void or adjustment will apply to the entire claim.

**BLOCK 23 PRIOR AUTHORIZATION NUMBER (REQUIRED)**
Enter the DHS/DDD prior authorization number generated from the IRIS service authorization system.

**BLOCK 24**
Use a separate line for each service provided. If billing on paper and more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed; continued claims

are not accepted. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code.

**24A. DATE OF SERVICE FROM – TO *(MANDATORY)***
Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion.

| | FROM | TO |
|---|---|---|
| Example: | 100116 | 103116 |

***Reserve bed days*:** A recipient may be absent due to an inpatient hospital stay for a maximum of five days and the recipient must return to the facility for 24 hours before additional reserve bed days may be paid. Bill reserve bed days on the same line as other payable days and do not bill for non-payable days.

Do not include the recipient's date of discharge or date of death in the dates of service.

**24B. PLACE OF SERVICE *(MANDATORY)***
Enter the appropriate place of service code.
Code values:

| | |
|---|---|
| 02 | Telehealth Provided Other than in the Patient's Home |
| 03 | School |
| 10 | Telehealth Provided in the Patient's Home |
| 12 | Home |
| 14 | Group Home |
| 18 | Place of Employment – Worksite |
| 77 | Audio-Only Service |
| 99 | Other Place of Service |

**24D. PROCEDURE CODE *(MANDATORY)***
Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPCS) code for the approved service provided. Enter the appropriate procedure modifier, if applicable. Use the same procedure code only once per date of service. A procedure code may be listed more than once per date of service if an applicable modifier is included.

Please refer to the CHOICES Waiver Fee Schedule located on the DSS website.

**24E. DIAGNOSIS POINTER *(MANDATORY)***
Enter A – L which correlates to the diagnosis code entered in Block 21. The Diagnosis Pointer relates to the reason the service was performed. A maximum of four diagnosis pointers may be entered per line. Do not enter the diagnosis code in 24E.

**24F. CHARGES *(MANDATORY)***
This is a simple formula. The number entered should be the service rate as identified on the fee schedule and authorized by DHS/DDD multiplied by the number of units provided. South Dakota Medicaid will pay the authorized amount for each service, up to the billed amount.

*Example: T2020 U7 (14.40 unit rate per hour) x 400 units= $5760 charges*

Do not enter dollar signs or special characters; for example, if the billed amount is $1,500.00 enter 1500.00. Do not enter the recipient cost share amount in the shaded area; this amount will be deducted by the system. If the cost share amount is entered it will result in an additional reduction from the final payment.

**24G. DAYS OR UNITS *(MANDATORY)***

Enter the number of units that the procedure or service was provided for this recipient during the period covered by the dates in block 24A. This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments. Billed units shall not exceed 999. Date spans where the units exceed 999 must be split into two separate lines with non-overlapping dates.

**24I. ID QUALIFIER** ***(MANDATORY)***
Enter ZZ.

**24J. TAXONOMY AND RENDERING PROVIDER ID #** ***(MANDATORY)***
(Shaded) Enter 261QD1600X.
(Unshaded) Enter the facility NPI number in the unshaded portion of the field. This will be the same NPI that is used in 33A.

## BLOCK 25 FEDERAL TAX ID NUMBER *(MANDATORY)*

The number assigned to the provider by the federal government for tax reporting purposes; also known as a tax identification number (TIN) or employer identification number (EIN).

## BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER *(MANDATORY)*

The claim must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without a signature and date completed.

## BLOCK 33 PROVIDER NAME, ADDRESS AND ZIP CODE *(MANDATORY)*

Enter the billing provider's name and facility address as shown on the SD MEDX Enrollment record.

**33A.** ***(MANDATORY):*** Enter the billing NPI number of the facility.

**33B.** ***(MANDATORY):*** Enter ZZ261QD1600X with no spaces.

# HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | 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): 111111111

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

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 _____

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 0

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F70 B. C. D.

E. F. G. H.

I. J. K. L. 0

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER C000000

| 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 | 06 01 23 | 06 30 23 | 14 | | T2016 | U1 UR | | A | 6240 99 | 30 | | ZZ | 261QD1600X |
| | | | | | | | | | | | | NPI | 1111111111 |
| 2 | 06 01 23 | 06 30 23 | 99 | | T2020 | U7 | | A | 5760 | 400 | | ZZ | 261QD1600X |
| | | | | | | | | | | | | NPI | 1111111111 |
| 3 | 06 01 23 | 06 30 23 | 18 | | T2019 | HJ UN | | A | 3528 | 200 | | ZZ | 261QD1600X |
| | | | | | | | | | | | | NPI | 1111111111 |
| 4 | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN X

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.)

John Doe 07012023

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

WAIVER PLACE
123 HAPPY STREET
PIERRE, SD 57501

a. 1111111111 b. ZZ261QD1600X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION