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 (SD) 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.

As of February 1, 2018 you may only void prior submitted UB claims. Once the claim is voided, please resubmit the charges on the CMS 1500 form.

**BLOCK 24**
Use a separate line for each date span. If billing on paper and more than six date spans were provided in a single calendar month then 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.

Example: FROM 100117 TO 103117

Hospital reserve bed days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to SD Medicaid per hospitalization; however, the recipient must return to the ALC for a minimum of 24 hours before additional hospital reserve bed days will be paid. Hospital reserve bed days must be billed with a code of 21 in 24B for the place of service.

Therapeutic leave days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Assisted Living Center for non-medical reasons (e.g., visits to the homes of family or friends). Therapeutic leave days must be billed with a code 12 in 24B for the place of service.

Note: 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:
12 Home
13 Assisted Living Center
21 In-Patient Hospital

24D. PROCEDURE CODE (MANDATORY)
Enter the appropriate five character Healthcare Common Procedure Coding System (HCPCS) code for the approved service provided.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>T2031</td>
<td>Assisted Living</td>
</tr>
</tbody>
</table>

NOTE: Use the same procedure code only once per date of service.

24E. DIAGNOSIS POINTER (MANDATORY)
Enter A – L which correlates to the diagnosis code entered in Block 21.

24F. CHARGES (MANDATORY)
Enter the provider’s usual and customary charge for this service in the unshaded portion. For example, if the usual and customary charge is $50.00 enter 50.00.

24G. DAYS OR UNITS (MANDATORY)
Enter the number of days that the service was provided for this recipient during the period covered by the dates in block 24A. The units must equal the date of service span.

24I. ID QUALIFIER (MANDATORY)
Enter ZZ.
24J. TAXONOMY AND RENDERING PROVIDER ID # (OPTIONAL)
   1. Enter 310400000X Enter the ALC NPI number in the unshaded portion of the field or leave blank. 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 ALC address as shown on the SD MEDX Enrollment record.
   33A. (MANDATORY): Enter the billing NPI number of the Assisted Living Center.
   33B. (MANDATORY): Enter ZZ310400000X with no spaces.
# Health Insurance Claim Form

**National Uniform Claim Committee (NUCC) 03/12**

**Patient Information**

- **Patient's Name:** Smith, Jane
- **Address:** 
  - City: 
  - State: 
  - ZIP Code: 
- **Relation to Insured:** Self
- **Insured's Name:** 
  - Last Name: 
  - First Name: 
  - Middle Initial: 
- **Telephone:** 
- **Sex:** M
- **Date of Birth:** MM DD YY

**Other Insured Information**

- **Other Insured's Name:** 
  - Last Name: 
  - First Name: 
  - Middle Initial: 
- **Other Insured's Date of Birth:** MM DD YY
- **Other Insured's Sex:** M

**Employment Information**

- **Employer:** 
- **Position:** 
- **Address:** 
- **Phone:** 

**Other Claims Information**

- **Other Claim ID:** 
  - Designated by NUCC: Y
  - ID: 

**Additional Claim Information**

- **ICD-10 Code:** F70
- **Diagnosis:** 
- ** Modifier:** 0

**Procedure or Service Information**

| Procedure Code | Description | Date of Service | Days | Charges | HCPCS Code | Modifier | F. CH | GP | H | I.D. | J. Rendering Provider
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<td>NPI</td>
<td>3104000000X</td>
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</tr>
</tbody>
</table>

**Financial Information**

- **Patient Identification:** 
  - SSN: 
- **Total Charge:** $1500.00
- **Amount Paid:** $1500.00
- **Balance Due:** $0.00

**Provider Information**

- **Signature:** John Doe
- **Date:** 11-01-17
- **NPI:** 

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**Signature:**

**Print or Type:**

**Approved OMB-0938-1197 FORM CMS-1500 (02-12)**