4.   CMS-1500 Claim Form Instructions

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the CMS-1500 billing form and must be used in conjunction with the Mississippi Administrative Code Title 23. Professional providers are strongly encouraged to bill electronic claims to reduce the potential for errors and speed reimbursement The Administrative Code and fee schedules should be used as a reference for issues concerning policy and the specific procedures for which Medicaid reimburses. Contact the fiscal agent's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222 for questions and assistance.

4.1.   Provider Types

The instructions for the CMS-1500 claim form are to assist the following types of providers:

- Ambulance
- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetists
- Chiropractic Care
- Community/Private Mental Health Centers
- Durable Medical Equipment (DME)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening Providers
- Federally Qualified Health Centers
- Hearing Aid Providers
- Independent Laboratory
- Independent Radiology
- Mental Health Services
- Nurse Practitioners
- Optical/Vision Providers
- Perinatal High-Risk Management
- Pharmacy Disease Management
- Physicians
- Physician Assistants
- Podiatrists
- Prescribed Pediatric Extended Care
- Private Duty Nursing
- Rural Health Clinics
- Therapy Services (physical, occupational, and speech)
- Waiver Services

4.2. MESA Web Portal Reminder

Providers are encouraged to use the MESA Web Portal for easy access to up-to-date information. The MESA web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The MESA web portal is available 24 hours a day, seven days a week, 365 days a year via the Internet at https://portal.ms-medicaid-mesa.com/MS/Provider.

4.3. Paper Claim Guidelines

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- An original CMS-1500 claim form must be completed.

- No photocopied or fax claims are accepted.

- Do not include handwritten information on the claim form.

- Blue or black ink must be used to fill out the form.

- The information on the form must be legible.

- No highlighters should be used.

- Correction fluid or correction tape should not be used.

- Names, codes, numbers, etc. must print in the designated fields for proper alignment.

- Claim must be signed. Rubber signature stamps are acceptable.

- The six service lines in Locator 24 have been divided horizontally to accommodate submission of supplemental information along with NPI and other identifiers such as taxonomy codes or legacy identifiers. The top, shaded portion of each service line is for reporting supplemental information (i.e., NDC code). It is not intended to allow the billing of twelve service lines. Each procedure, service, drug, or supply must be listed on its own claim line in the bottom, unshaded portion of the claim line.

4.4. Paper Claims with Attachments

When submitting attachments with the CMS-1500 claim form, the below guidelines should be followed:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.

- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim on standard 8½-by-11-inch paper.

- For claims with third- party payor source, all EOBs that relate to the claim must be included.

4.5. Multi-Page Paper Claims

When submitting CMS - 1500 claims with multiple pages, the below guidelines should be followed:

- Multi-page claims are limited to 9 pages with a maximum of 50 claim lines. The 9th page should only be used to bill two detail lines.

- The first form should not be totaled, the total should be indicated on the last page.

- Pages together must be clipped together.

- Indicate Multipage Page count X of 9 in FL 19 (Figure 32).

- If reporting a Third-Party Liability (TPL) payment, indicate it in FL 29 (Figure 51) of the last page.
- Only one copy of an attachment (e.g., EOB, EOMB, and Consent Form) is required per claim.

4.6. Electronic CMS-1500 Claims

Electronic CMS-1500 claims may be submitted to Mississippi Medicaid by:

- Using the Web Portal Claims Entry feature
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid

Electronic CMS-1500 claims must be submitted in a format that is HIPAA compliant with the American National Standard Institute (ANSI) X12 837P claim standards.

4.7. Claim Mailing Address

Once the claim form has been completed and checked for accuracy, the completed claim form can be mailed to:

Mississippi Medicaid Program

PO Box 23076

Jackson, MS 39225-3076

4.8. CMS-1500 Claim Form Instructions (Version 02/12)

On August 01, 2014, Mississippi Medicaid began receiving and processing paper claims submitted only on the revised CMS-1500 Claim Form (version 02/12). The field instructions are as follows.

Figure 1. FL 1 Required: Type of Insurance

Instructions: Indicate the type(s) of insurance coverage applicable to this claim. Enter an "X" in the box marked Medicaid.

Instructions: Indicate the type(s) of insurance coverage applicable to this claim. Enter an "X" in the box marked Medicare for claims where the member has Medicare Coverage.

Figure 2. FL 1a Required: Insured's ID Number

Instructions: Enter the member's nine-digit identification number as listed on their Medicaid card.

Figure 3. Example of Insured's Medicaid ID Card

Figure 4. FL 2 Required: Patient Name

Instructions: Enter the member's name as it appears on the Medicaid ID card in the last name, first name, and middle initial format.

Figure 5. FL 3 Required: Patient Birth Date, Sex

Instructions: The date format is eight digits MM/DD/CCYY (e.g., 01011991). Enter the month, day, and year of birth of the member. If the full birth date is unknown, indicate zeros for all eight digits.

Enter the sex of the patient. If Sex is Unknown, do not mark either the "F" or "M" box

- F- Female
- M – Male
- U – Unknown

Figure 6. FL 4 Not Required: Insured Name

Instructions: Leave this field blank.

Figure 7. FL 5 Not Required: Patient Address

Instructions: Leave this field blank.

Figure 8. FL 6 Not Required: Patient Relationship

6. PATIENT RELATIONSHIP TO INSURED

Self ☐ Spouse ☐ Child ☐ Other ☐

Instructions: Leave this field blank.

Figure 9. FL 7 Not Required: Insured Address

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

Instructions: Leave this field blank.

Figure 10. FL 8 Not Required: Reserved for NUCC USE

8. RESERVED FOR NUCC USE

Instructions: Leave this field blank.

Figure 11. FL 9 Situational: Other Insured Name

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

Doe, Mary A.

Instructions: Enter the last name, first name, and middle initial format of the member if different than shown in FL 2 (Figure 4). The other insured name indicates that there is a holder of another policy that may cover the patient.

Figure 12. FL 9a Situational: Other Insured Policy or Group Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER

72431

Instructions: Enter policy number of the other insured as it appears on the insured's Insurance ID card. If group number is available, enter both.

Note: The policy number is used to verify the policy by the Office of Third Party Liability/Recovery, when applicable.

Figure 13. FL 9b Not Required: Reserved for NUCC Use

b. RESERVED FOR NUCC USE

Instructions: Leave this field blank.

Figure 14. FL 9c Not Required: Reserved for NUCC Use

c. RESERVED FOR NUCC USE

Instructions: Leave this field blank.

Figure 15. FL 9d Situational: Insurance Plan or Program Name

d. INSURANCE PLAN NAME OR PROGRAM NAME

Merit Insurance

Instructions: Enter the other insured's insurance plan or program name.

Figure 16. FL 10a-c Situational: Is Patient's Condition Related To:

    a. Employment?

    b. Auto Accident?

    c. Other Accident?

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)
    ☐ YES   ☒ NO

b. AUTO ACCIDENT?   PLACE (State)
    ☐ YES   ☒ NO

c. OTHER ACCIDENT?
    ☐ YES   ☒ NO

Instructions: Check the appropriate box to indicate whether one or more of the services described in FL 24 a-j (Figures 37-46) are for a condition or injury that occurred on the job or as a result of an auto accident or other accident.

Note: Enter the State code if 10b. is checked "YES". Any item checked "YES" indicates there may be other insurance primary to Medicaid. Identify primary insurance information in FL 11 (Figure 18).

Figure 17. FL 10d Situational: Claim Codes

10d. CLAIM CODES (Designated by NUCC)

AI

Instructions: When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the National Uniform Claim Committee (NUCC) under Code Set https://www.nucc.org/.

Figure 18. FL 11 Situational: Insured's Policy Group or Federal Employees Compensation Act (FECA) Number
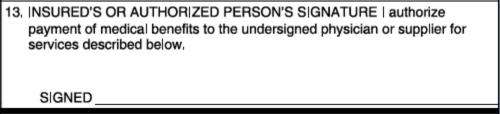
11. INSURED'S POLICY GROUP OR FECA NUMBER

15974

Instructions: Enter the insured's policy or group number as it appears on the insured's healthcare identification card.

Figure 19. FL 11a Not Required: Insured's Date of Birth, Sex

a. INSURED'S DATE OF BIRTH   SEX
    MM DD YY   M ☐   F ☐

Instructions: Leave this field blank.

Figure 20. FL 11b Situational: Other Claim ID

b. OTHER CLAIM ID (Designated by NUCC)

Instructions: When applicable, use to report appropriate Other Claim ID. Applicable Other Claim ID are designated by the NUCC under Code Set https://www.nucc.org/.

Figure 21. FL 11c Situational: Insurance Plan Name or Program Name

c. INSURANCE PLAN NAME OR PROGRAM NAME

Instructions: Enter the other insured's insurance plan or program name.

Figure 22. FL 11d Not Required: Is There Another Health Benefit Plan?

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

☐ YES   ☐ NO   *If yes*, complete items 9, 9a, and 9d.

Instructions: Leave this field blank.

Figure 23. FL 12 Situational: Patient Signature

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 _Signature or "Signature on File"_   DATE MM/DD/CCYY

Instructions: Enter the member signature or signature on file with the date in MM/DD/CCYY format.

Figure 24. FL 13 Not Required: Insured's or Authorized Person's Signature

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 _____

Instructions: Leave this field blank.

Figure 25. FL 14 Situational: Date of Current Illness, Injury, or Pregnancy

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

Instructions: For current illness, injury, or pregnancy, enter the date in the MM/DD/CCYY format.

Valid Values:

- 431 = Onset of current symptoms or illness
- 439 = Injury
- 484 = LMP

Figure 26. FL 15 Situational: Other Date

Instructions: Enter other date in the MM/DD/CCYY format. Applicable Qualifiers are designated by the NUCC under Code Set https://www.nucc.org/.

Figure 27. FL 16 Not Required: Date Patients Unable to Work in Current Occupation

Instructions: Leave this field blank.

Figure 28. FL 17 Situational: Name of Referring Provider or Other Source

Instructions: Enter referring or ordering provider information, including the following:

- Provider Qualifier
  - Valid Values:
    - DN – Referring Provider
    - DK – Ordering Provider
    - DQ – Supervising Provider
- First and Last Name

Note: Lab, DME, and radiology claims require ordering physician to be entered.

Figure 29. FL 17a Required: Other ID Number

Instructions: Enter the nine-digit Medicaid provider number of the ordering/referring provider and the appropriate qualifier.

Qualifier valid values are:

- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Medicaid ID
- LU – Location Number (Used for Supervising Provider only)
- ZZ – Taxonomy

Figure 30. FL 17b Required: Referring/Ordering NPI

Instructions: Enter the ten-digit NPI number.

Figure 31. FL 18 Situational: Hospitalization Dates Related to Current Services

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
	MM	DD	YY	MM	DD	YY
FROM	01	03	20	TO 01	03	20

Instructions: Enter the date of hospital admission and discharge if the services billed are related to a hospitalization. If the patient has not been discharged, leave the discharge date blank.

Figure 32. FL 19 Situational: Additional Claim Information (Designated by NUCC)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Instructions: Use this field for when submitting a multi-page claim to indicate page count X of 9.

Figure 33. FL 20 Not Required: Outside Lab Charges

20. OUTSIDE LAB? $ CHARGES
☐ YES   ☐ NO

Instructions: Leave this field blank.

Figure 34. FL 21 Required: Diagnosis or Nature of Illness or Injury

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

A. R06.00	B. J18.9	C. N39.0	D.
E.	F.	G.	H.
I.	J.	K.	L.

Instructions: Enter the appropriate International Classification of Diseases (ICD) indicator for the date of service.

Note: The ICD indicator must be 0 (ICD-10-CM), 9 (ICD-9-CM), or blank. At least one Diagnosis code is required with eight characters or less.

Figure 35. FL 22 Situational: Resubmission Code (Original Reference No.)

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7	2120364026258

Instructions: This form locator is used for submitting an adjustment or a void. Enter a 7 in the resubmission code area to indicate an adjustment/replacement. Enter an 8 in the resubmission code area to indicate a void. Enter previous ICN or Transaction Control Number (TCN) assigned to the claim in the "Original Reference No" area. Additionally, please indicate "Adjustment" or "Void" in the blank space in the top right hand corner of the claim form. See Figure 60.

Figure 36. FL 23 Situational: Prior Authorization Number

23. PRIOR AUTHORIZATION NUMBER
A1234567

Instructions: Enter an authorization number without hyphens, dashes, spaces, etc. Enter only one authorization per one claim form.

Figure 37. FL 24a Required: Date of Service (lines 1-6)

Instructions: Enter the date for each procedure, service, or supply in MM/DD/YY format. When "From" and "To" dates are shown for a service of identical services, enter the number of days or units in FL 24g (Figure 43).

Figure 38. FL 24b Required: Place of Service

Instructions: Enter the appropriate two-digit code for the place of service code. The Place of Service Codes are available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Figure 39. FL 24c Situational: EMG

Instructions: Enter "Y" (Yes) or "N" (No) in the appropriate box.

Figure 40. FL 24d Required: Procedures, Services, or Supplies

Instructions: Enter the following information:

- **Procedure Code** – Enter the appropriate Current Procedural Terminology (CPT)-4 / Healthcare Common Procedures Coding System (HCPCS) code that identifies the service provided.

- **Procedure Modifier** – Enter the appropriate procedure modifier that further qualifies the service provided. (Note: This field should only be used when applicable.)

Note: Some mental health providers are required to enter a specific modifier for each claim line. Fee schedules identifying modifier requirements are available at: Fee Schedules and Rates.
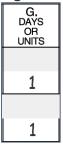
Figure 41. FL 24e Required: Diagnosis Pointer

E. DIAGNOSIS POINTER
A
B

Instructions: Enter one diagnosis indicator (A, B, C, D, E, F, G, H) that identifies appropriate diagnosis for the procedures. These indicators should correspond to the line numbers of the diagnosis codes listed in FL 21 (Figure 34).

Figure 42. FL 24f Required: Charges (lines 1-6)

F. $ CHARGES	
50	00
250	00

Instructions: Enter the charge for each listed service/procedure. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the right-hand area of the field if the amount is a whole number.

Figure 43. FL 24g Required: Days or Units Billed

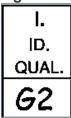| G. DAYS OR UNITS |
| --- |
| 1 |
| 1 |

Instructions: Enter the number of days or units. This field is most used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Figure 44. FL 24h Situational: EPSDT/ Family Planning

Instructions: When there is a requirement to report a Family Planning service, enter "F"; when there is a requirement to report this as a EPSDT service, enter "E". When there is no requirement for Family Planning Services or EPSDT, leave the field blank.

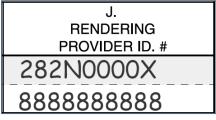**Figure 45. FL 24i Required: ID Qualifier**

Instructions: Enter the appropriate qualifier to identify if the number is a non-NPI.

Qualifier valid values are:

- 0B – State License Number
- 1G – Provider UPIN Number
- G2 – Provider Medicaid ID
- LU – Location Number (Used for Supervising Provider only)
- ZZ – Taxonomy

Figure 46. FL 24j Required: Rendering Provider ID and NPI

Instructions: Enter the rendering provider's Taxonomy (ZZ) or related value to the qualifiers (0B, 1G, G2, and LU) in the shaded half of the claim line. Enter the ten-digit NPI in the bottom, (un-shaded half of the claim line).

Figure 47. FL 25 Not Required: Federal Tax ID or SSN

Instructions: Leave this field blank.

Figure 48. FL 26 Situational: Patient Account Number

26. PATIENT'S ACCOUNT NO.

123548F

Instructions: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist the provider in patient identification.

Figure 49. FL 27 Not Required: Accept Assignment?

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

Instructions: Leave this field blank.

Figure 50. FL 28 Required: Total Charge
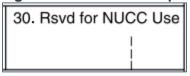
28. TOTAL CHARGE

$ 300 | 00

Instructions: Enter total charges for the services [i.e., total of all charges in FL 24f (Figure 42)].

Figure 51. FL 29 Situational: Amount Paid
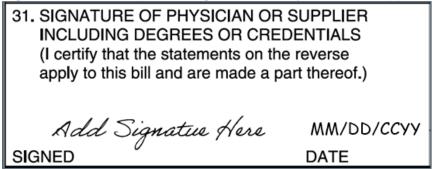
29. AMOUNT PAID

$ 125 | 00

Instructions: Enter total amount the member and/or other payers paid on the covered services only.

Figure 52. FL 30 Not Required: Reserved for NUCC Use

30. Rsvd for NUCC Use

Instructions: Leave this field blank.

Figure 53. FL 31 Required: Signature of Physician or Supplier and Date

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.)

Add Signatue Here   MM/DD/CCYY
SIGNED   DATE

Instructions: Enter the signature of provider of service or supplier, or his/her representative, and the date in the MM/DD/CCYY format or alphanumeric date (e.g., January 01, 2022).

Figure 54. FL 32 Situational: Service Facility Location

```
32. SERVICE FACILITY LOCATION INFORMATION
    ABC Hospital
    123 Easy Street
    Anytown, PA  19003
```

Instructions: Enter the service location where the services were rendered in the following format:

- Facility Name
- Street Address
- City, State Zip Code

Figure 55. FL 32a Situational: Service Facility NPI

```
a.   0123456789
```

Instructions: Enter the NPI of the servicing provider.

Figure 56. FL 32b Situational: Service Facility Other ID #

```
b.   282N0000X
```

Instructions: Enter the qualifier ZZ followed by the Taxonomy code if the NPI was used in FL 32a. Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility.

Figure 57. FL 33 Required: Billing Provider Info and Phone Number

```
33. BILLING PROVIDER INFO & PH #    ( 215 ) 555-5555
    ABC Medical Group
    8 North American Street
    Anytown, PA  19003
```

Instructions: Enter the billing provider name (last name, first name), address (including the expanded ZIP Code+4), and telephone number currently on file with DOM as the billing provider where services were rendered.

Figure 58. FL 33a Required: Billing Provider NPI

```
a. 2222222222
```

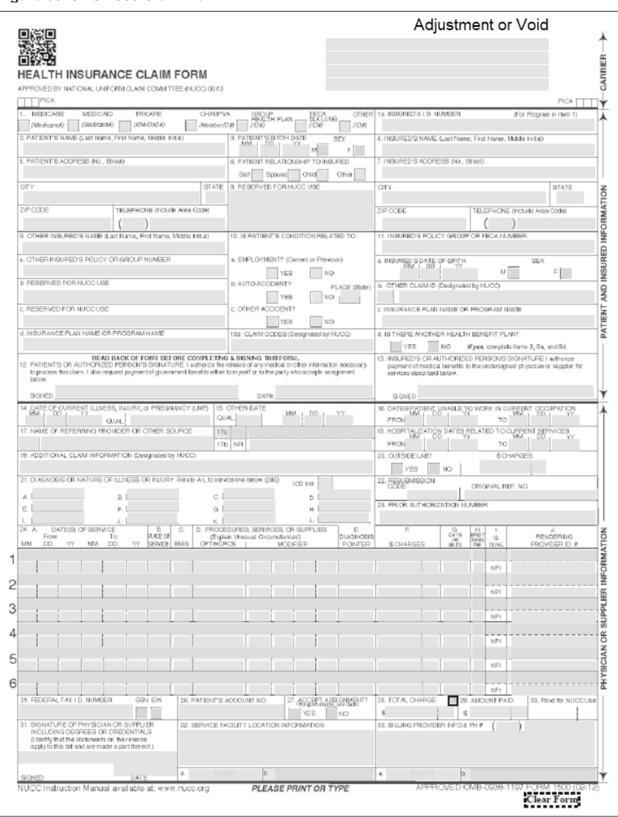Instructions: Enter the NPI of the billing provider.

Atypical providers are required to enter the Medicaid provider ID on field 33b.

Figure 59. FL 33b Required: Billing Provider Other ID#

```
b.   282N0000X
```

Instructions: Enter the qualifier ZZ followed by the Taxonomy code if the NPI was used in FL 33a. Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the provider.

Figure 60. CMS-1500 Claim Form

4.9.   Filing Medicare Crossover Claims on the CMS-1500

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

- In FL 1 (Figure 1), enter X in the box labeled "Medicare" when submitting a crossover claim and enter X in the box labeled "Medicaid" for non-crossover claims.

- Ensure that the beneficiary's nine-digit Medicaid number is in FL 1a (Figure 2).

- Enter the NPI number of the billing provider who is the one to which Medicaid payment will be made in FL 33 (Figure 57). If FL 33 contains a group NPI provider number, enter the ten-digit NPI of the servicing/ rendering provider in FL 24j (Figure 46).

- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.

- The claim detail information should match the individual EOMB detail level information.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.

- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.

- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).

- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

The MISSISSIPPI CROSSOVER CLAIM FORM will no longer be accepted.

Please mail claim forms to:

Mississippi Medicaid Program

PO Box 23076

Jackson, MS 39225-3076