Blue Cross Blue Shield of Rhode Island
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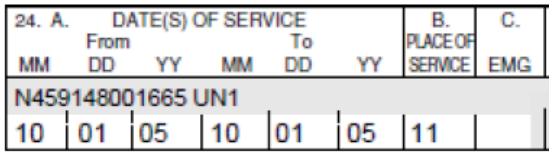
Blue Cross & Blue Shield of Rhode Island
CMS-1500 (02/12) Form Completion Informational Guide

All professional provider services filed to Blue Cross & Blue Shield of Rhode Island (BCBSRI) must be filed on a CMS-1500 paper claim form or using an electronic format. Instructions for completing each field of the CMS-1500 (02/12) claim form are listed below. **To ensure prompt payment from BCBSRI, please include as much information as possible. The fields identified with the *blue type* are mandatory.**

Field	Name of Field	Information to Enter
1	Type of Insurance	Mark an "X" in the subscriber's corresponding health insurance type. Only one box can be marked.
1a	Insured's I.D. Number	Enter the insured **subscriber's** BCBSRI identification number including the three-digit alpha prefix.
2	Patient's Name	Enter the last name, first name, and middle initial of the **patient.**
3	Patient's Birth Date, Sex	Enter the patient's date of birth (MM/DD/YYYY) and an "X" in appropriate box (M or F). If sex is unknown, leave blank.
4	Insured's Name	Enter the last name, first name, and middle initial of insured **subscriber.**
5	Patient's Address (multiple fields)	Enter the number, street, city, state, ZIP code, and telephone number (including area code) of the **patient**.
6	Patient Relationship to Insured	Mark an "X" in appropriate box (self, spouse, child, or other).
7	Insured's Address	Enter the number, street, city, state, ZIP code, and telephone number (including area code) of insured **subscriber**. If the insured's address is the same as Field 5, enter "Same."
8	Reserved for NUCC Use	Field not used.
9	Other Insured's Name	If there is a holder of another policy that may cover the patient, enter the other insured's last name, first name, and middle initial, *if different* from that shown in Field 2.
9a	Other Insured's Policy or Group Number	Enter the other insured's policy/and or group number identified in Field 9.
9b	Reserved for NUCC Use	Field not used.
9c	Reserved for NUCC Use	Field not used.
9d	Insurance Plan Name or Program Name	Enter the insurance plan name or program name of the other insured identified in Field 9.
10a – 10c	Is Patient's Condition Related to:	Check "Yes" or "No" to indicate whether (a) Employment, (b) Auto Accident, or (c) Other Accident applies to any of the services described in Field 24.
10d	Claim Codes (Designated by NUCC)	When applicable, use this field to report appropriate claim codes that are designated by NUCC. When reporting more than one code, enter three blank spaces and then the next code.
11	Insured's Policy Group or FECA Number	Enter the insured's policy, group, or FECA (Federal Employees Compensation Act) number from their identification card.

Field	Name of Field	Information to Enter
11a	Insured's Date of Birth and Sex	Enter the insured's date of birth (MM/DD/YYYY) and an "X" in appropriate box (M or F) from Field 1a.
11b	Other Claim ID (Designated by NUCC)	Enter the other claim identifiers applicable to the claim. Applicable claim identifiers are designated by the NUCC.
11c	Insurance Plan Name or Program Name	Enter the insurance plan name or program name referring to Field 1a.
11d	Is There Another Health Benefit Plan?	Indicate by an "X" that the patient does or does not have insurance coverage other than the plan indicated in Field 1. If marked "yes", complete Fields 9, 9a, and 9d.
12	Patient's or Authorized Person's Signature and Date	Enter "Signature of File", "SOF", or legal signature. When legal signature, enter date (MM/DD/YYYY). This field indicates that there is an authorization on file for release of any medical or other information necessary to process the claim. If there is no signature on file, leave blank or enter "No signature on file."
13	Insured's or Authorized Person's Signature	Enter "Signature of File," "SOF," or legal signature. This field indicates that there is a signature on file authorizing payment of medical benefits. If there is no signature on file, leave blank or enter "No signature on file."
14	Date of Current: Illness, Injury, or Pregnancy (LMP)	Enter the first date (MM/DD/YYYY) of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to the right of the vertical, dotted line. Use "431" for onset of current symptoms or illness, or "484" for LMP.
15	Other Date	Enter another date (MM/DD/YYYY) related to the patient's condition and treatment. Enter the applicable qualifier to identify which date is being reported. • 454 – Initial treatment • 304 – Latest visit or consultation • 453 – Acute manifestation of a chronic condition • 439 – Accident • 455 – Last X-ray • 471 – Prescription • 090 – Report start (assumed care date) • 091 – Report end (relinquished care date) • 444 – First visit or consultation
16	Dates Patient Unable to Work in Current Occupation	Enter if the patient is employed and is unable to work in current occupation. Enter **"from"** and **"to"** dates (MM/DD/YYYY), indicating the dates the patient is unable to work.
17	Name of Referring Provider or Other Source Please note: Fields 17, 17a, and 17b are only mandatory if there is a referring provider. If there isn't one, leave blank.	Enter the name (first name, middle initial, last name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If there is no referring provider or if a self-referral, please leave all of Field 17 (including 17a and 17b) blank. If there are multiple providers involved, enter **one** provider using the following priority order: 1. Referring Provider 2. Ordering Provider

Field	Name of Field	Information to Enter
		3. Supervising Provider Additionally, enter the applicable qualifier to identify which provider is being reported: • "DN" – Referring Provider • "DK" – Ordering Provider • "DQ" – Supervising Provider
17a	Other ID#	Enter the non-NPI ID number of the referring, ordering, or supervising provider that will be the unique identifier of the provider-designated taxonomy code. Enter the two-digit qualifier before the other ID number. Qualifiers are: • "OB" – State License Number • "1G" – Provider UPIN Number • "G2" – Provider Commercial Number • "LU" – Location Number (Supervising Provider Only) **If the provider does not have a unique identifier, leave blank.**
17b	NPI of Referring Physician	Enter the NPI of the referring, ordering, or supervising provider listed in Field 17.
18	Hospitalization Dates Related to Current Services	Enter the inpatient hospital admission date (MM/DD/YYYY) followed by the discharge date (if discharge has occurred). If no discharge date, leave discharge date blank.
19	Additional Claim Information (Designated by NUCC)	Leave Blank
20	Outside Lab? $ Charges	Complete this field when billing for purchased services by entering an "X" in "Yes." This indicates that the reported service was provided by an entity other than the billing provider.
21	Diagnosis or Nature of Illness or Injury	Enter the applicable ICD indicator (upper right-hand of the box) to identify which version of ICD codes is being reported. • "9" – ICD-9-CM • "0" – ICD-10-CM Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes in lines A – L. IMPORTANT – You cannot mix ICD-9-CM codes and ICD-10-CM codes on the same claim. It must be submitted with either all ICD-9-CM codes or all ICD-10-CM codes.
22	Resubmission and/or Original Reference Number	List the original reference number for previously submitted claims. When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. • "7" – Replacement of prior claim • "8" – Void/cancel of prior claim
23	Prior Authorization Number	Enter the prior authorization number, referral number, mammography precertification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

Field	Name of Field	Information to Enter
24a	Date(s) of Service – Lines 1 through 6	Enter the date(s) of service (MM/DD/YY) in both the "From" and "To" dates. If there is only one date of service, enter that date under "From." Use the grey space above the date to enter any NDC codes. NDC should be entered in the following order: *"N4" qualifier, the NDC code, one space, unit/basis of measurement qualifier*, and quantity*. Do not use decimals or commas. Example:  24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG MM DD YY MM DD YY N459148001665 UN1 10 01 05 10 01 05 11 *Unit/basis of measurement qualifier for BCBSRI = "UN"
24b	Place of Service – Lines 1 through 6	Enter the appropriate two-digit code from the Place of Service Code List for each item used or service performed. You can find the Place of Service Code List at www.cms.gov.
24c	EMG – Lines 1 through 6	If the service(s) rendered is for an emergency, enter "Y" for "Yes" or leave blank if "No" in the bottom, unshaded area of the field.
24d	Procedures, Services, or Supplies – Lines 1 through 6	Enter the CPT® or HCPCS© code(s) and any applicable modifier(s) from the appropriate code set in effect on the date of service. This field identifies the medical services and procedures provided to the patient.
24e	Diagnosis Pointer – Lines 1 through 6	Enter the diagnosis code reference letter (pointer) as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. The reference letter(s) should be A-L or multiple letters as applicable.
24f	$Charges – Lines 1 through 6	Enter monetary charge for each listed service. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.
24g	Days or Units – Lines 1 through 6	Enter the number of days or units. If only one service is performed, the numeral "1" must be entered. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.
24h	EPSDT Family Plan – Lines 1 through 6	Used for Early & Periodic Screening, Diagnosis, and Treatment related services.
24i	ID Qualifier – Lines 1 through 6	If the provider does not have an NPI number, enter the qualifier identifying that the number is a non-NPI in the shaded area.
24j	Rendering Provider ID# – Lines 1 through 6	Enter the NPI of the rendering provider in the *unshaded* area. If the provider does not have an NPI number, enter the non-NPI number in the shaded area.
25	Federal Tax ID Number	Enter the Federal Tax ID Number (employer ID number or SSN) of the Billing Provider identified in Field 33. This is the tax ID number intended to be used for 1099 reporting purposes.
26	Patient's Account Number	Enter the patient's account number assigned by the provider of service's or supplier's accounting system.
27	Accept Assignment?	Mark an "X" in the appropriate box (Yes or No) to indicate whether the provider of services or supplier accepts assignment under the terms of the payer's program.

Field	Name of Field	Information to Enter
28	Total Charge	Enter the total charges for the services (total of all charges in Field 24f). Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.
29	Amount Paid	Enter the payment received from the patient and/or other payers.
30	Reserved for NUCC Use	Field not used.
31	Signature of Physician or Supplier Including Degrees or Credentials	Enter the legal signature, date, and degree/credentials of the physician/provider/supplier of the services (or authorized representative), "Signature on File" or "SOF". Enter the date (MM/DD/YYYY) the form was signed.
32	Service Facility Location Information	Enter the name, address, and ZIP code of the location where the services were rendered.
32a	NPI#	Enter the NPI number of the service facility location from Field 32.
32b	Other ID#	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number.
33	Billing Provider Info & PH#	Enter the provider's or supplier's billing name, address, ZIP code, and phone number.
33A	NPI#	Enter the NPI of the billing provider from Field 33.
33B	Other ID#	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number.

For more information, refer to the NUCC (National Uniform Claim Committee) 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12© copyright 2013 American Medical Association at www.nucc.org.