This form is current as of July 25, 2008

Blue Cross & Blue Shield of Rhode Island

CMS-1500 (08-05) 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 (08-05) paper claim form or using an electronic format. Instructions for completing each field of the CMS-1500 (08-05) claim form are listed below. **To ensure prompt payment from BCBSRI, include as much information as possible. The fields identified with the *grey background and blue type* are mandatory for claims submitted to BCBSRI.**

Field	Name of Field	Information to Enter
1	Type of Insurance	Mark an "X" in the subscriber's corresponding health insurance type
1A	**Insured's I.D. Number**	**Insured subscriber's BCBSRI identification number including the 3-digit alpha prefix**
2	**Patient's Name**	**Last name, first name, and middle initial of patient**
3	**Patient's Birth Date/Sex**	**Date of birth (MM/DD/YY) and an "X" in appropriate box (M or F)**
4	Insured's Name	Last name, first name, and middle initial of insured subscriber
5	**Patient's Address**	**Number, street, city, state, ZIP code, and telephone number (including area code) of patient**
6	**Patient Relationship to Insured**	**Mark an "X" in appropriate box (self, spouse, child, or other)**
7	**Insured's Address**	**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	**Patient Status**	**Mark an "X" in the appropriate box for the patient's marital status, and whether "employed" or a "student"**
9	**Other Insured's Name**	**Last name, first name, and middle initial of the enrollee of another health plan, *if different* from that shown in Field 2**
9A	**Other Insured's Policy or Group Number**	**The other insured's policy/and or group number identified in Field 9**
9B	**Other Insured's Date of Birth and Sex**	**The date of birth (MM/DD/YY) of the other insured identified in Field 9 and an "X" in appropriate box (M or F)**
9C	**Employer's Name or School Name**	**The employer's name or school name of the other insured identified in Field 9**
9D	**Insurance Plan Name or Program Name**	**The insurance plan name or program name of the other insured identified in Field 9**
10A-C	**Is Patient's Condition Related to:**	**Check "YES" or "NO" to indicate whether employment (A), auto accident (B), or other accident (C) involvement applies to any of the services described in Field 24**
10D	**Reserved for Local Use**	***Exclusive to Medicaid information*. If patient is entitled to Medicaid, this field must be completed to reflect the patient's Medicaid number preceded by "MCD"**
11	Insured's Policy Group or FECA Number	The insured's policy, group, or FECA *(Federal Employees Compensation Act)* number. Also for worker's compensation carrier identifier

Field	Name of Field	Information to Enter
11A	Insured's Date of Birth and Sex	The insured's date of birth (MM/DD/YY) and an "X" in appropriate box (M or F) if different from Field 3
11B	Employer's Name or School Name	The employer's name, if applicable
11C	Insurance Plan Name or Program Name	The insurance plan name or program name referring to Field 1A
11D	Is There Another Health Benefit Plan?	Indicates by an "X" that the patient does or does not have insurance coverage other than the plan indicated in Field 1
12	Patient's or Authorized Person's Signature and Date	The patient or authorized representative must sign and enter a date unless the signature is on file, or a designated representative must sign on the patient's behalf
13	Insured's or Authorized Person's Signature	The signature in this item authorizes that there is a signature on file authorizing payment of medical benefits
14	Date of Current: Illness, Injury or Pregnancy	Date (MM/DD/YY) of current illness, injury, or pregnancy
15	If Patient Has Had Same or Similar Illness, Give First Date	Date (MM/DD/YY) that patient has had same or similar illness as indicated in Field 14. Indicates that patient had a previously related condition
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, enter date (MM/DD/YY) "from and to" indicating the dates the patient is unable to work
17	Name of Referring Provider or Other Source	The name of the referring or ordering physician if the service or item was referred by or ordered by a physician. *If there is no referring provider or if a self-referral, please leave all of Field 17 (including 17a and 17b) blank*
17A	ID Number of Referring Physician	Leave blank
17B	NPI of Referring Physician	NPI of the referring or ordering physician listed in Field 17
18	Hospitalization Dates Related to Current Services	Dates (MM/DD/YY) when a medical service is furnished as a result of, or subsequent to, a related hospitalization
19	Reserved for Local Use	Enter a concise description of an "unlisted procedure code"
20	Outside Lab? $ Charges	Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter purchase price under charges if the "yes" block is checked. "Yes" indicates that an entity other than the entity billing for the service performed the diagnostic test. When "yes" is annotated, Field 32 must be completed
21	**Diagnosis or Nature of Illness or Injury**	**Primary, secondary, tertiary, and quaternary diagnosis codes (ICD-9-CM©) in order of priority**
22	Medicaid Resubmission Code	The code and original reference number of a previously submitted claim or encounter
23	Prior Authorization Number	The prior authorization number for those procedures requiring prior approval. Enter the Investigational Device Exemption (IDE) number when an investigation device is used in an FDA-approved clinical trial. Post Market Approval (PMA) number should also be placed here when applicable
24A	**Date(s) of Service**	**Date (MM/DD/YY) for each procedure, service, or supply**
24B	**Place of Service**	**The code(s) for the place the service was rendered**

Field	Name of Field	Information to Enter
24C	EMG	Emergency indicator code. Leave blank
24D	**Procedures, Services, or Supplies**	**The procedures, services, or supplies using CPT®/HCPCS© codes and any applicable modifiers**
24E	**Diagnosis Pointer**	**The diagnosis code reference number (1, 2, 3, or 4) listed in Field 21**
24F	**$ Charges**	**The charge for each service listed on the corresponding lines**
24G	**Days or Units**	**Number of services provided (in days or units). This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume**
24H	EPSDT Family Plan	Enter "Yes" or "No" if the claim is related to "Early & Periodic Screening, Diagnosis, and Treatment."
24I	ID Qual.	Leave blank (for electronic submitters, enter "XX")
24J	**Rendering Provider I.D. #**	**Enter the NPI of the rendering provider in the *unshaded* area. Leave the shaded area blank for claims submitted to BCBSRI.**
25	**Federal Tax I.D. Number**	**The provider of service or supplier's Federal Tax ID (Social Security Number or Employer ID Number.) Mark an "X" in appropriate box (SSN or EIN).**
26	Patient's Account Number	The patient's account number assigned by the provider of service or supplier's accounting system
27	Accept Assignment?	Mark an "X" in the appropriate box (Yes or No) to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.
28	**Total Charge**	**Total charges for the services (total of all charges in Field 24f)**
29	Amount Paid	Total amount the patient paid on the covered services only
30	Balance Due	Total amount due
31	**Signature of Physician or Supplier Including Degrees or Credentials**	**Signature, date, and degree/credentials of the physician/provider/supplier of the services (or authorized representative)**
32	**Service Facility Location Information**	**The name, address, and ZIP code of the facility if the services were rendered in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office**
32A		NPI of the service facility
32B		Leave blank
33	**Billing Provider Info & PH #**	**Provider of service/supplier's billing name, address, ZIP code, and telephone number**
33A		**NPI of the billing provider or group**
33B		Leave blank