



BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.®

A Guide for Completing the

CMS-1500 Form

Version 08/05

TO ORDER CMS-1500 (08/05) FORMS:

<http://bookstore.gpo.gov>

OR CALL: (202) 512-1800

American Medical Association

P.O. Box 930876
Atlanta, GA 31193
(800) 621-8335

MAIL CLAIMS TO:

Blue Cross and Blue Shield of Oklahoma
P.O. BOX 3283
Tulsa, OK 74102-3283

You may also refer to the National Uniform
Claim Committee's "1500 Claim Form Instruction
Manual" at www.nucc.org.

Blue Cross and Blue Shield of Oklahoma offers
this guide to help you complete the CMS-1500
(08/05) form for your patients with
Blue Shield coverage.

Thank you for helping us to process your
claims efficiently and accurately.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <input type="checkbox"/>																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/>										3. PATIENT'S BIRTH DATE MM DD <input type="checkbox"/> SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/>																																																																															
5. PATIENT'S ADDRESS (No., Street) <input type="checkbox"/>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) <input type="checkbox"/>																																																																															
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																																																																															
ZIP CODE					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																																																																															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/>										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="checkbox"/>																																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="checkbox"/>										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME <input type="checkbox"/>																																																																															
c. EMPLOYER'S NAME OR SCHOOL NAME <input type="checkbox"/>										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="checkbox"/>																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="checkbox"/>										10d. RESERVED FOR LOCAL USE <input type="checkbox"/>										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.																																																																															
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. <input type="checkbox"/>																														13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <input type="checkbox"/>																																																																					
SIGNED _____															DATE _____															SIGNED _____																																																																					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY <input type="checkbox"/>										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY <input type="checkbox"/>										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD TO MM DD YY <input type="checkbox"/>																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <input type="checkbox"/>										17a. <input type="checkbox"/>										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD TO MM DD YY <input type="checkbox"/>																																																																															
19. RESERVED FOR LOCAL USE <input type="checkbox"/>										17b. NPI <input type="checkbox"/>										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) <input type="checkbox"/>										22. MEDICAID RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO. _____										23. PRIOR AUTHORIZATION NUMBER <input type="checkbox"/>																																																																															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY <input type="checkbox"/>										B. PLACE OF SERVICE <input type="checkbox"/>										C. EMG <input type="checkbox"/>										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER <input type="checkbox"/>										E. DIAGNOSIS POINTER <input type="checkbox"/>										F. \$ CHARGES <input type="checkbox"/>										G. DAYS OR UNITS <input type="checkbox"/>										H. EPSDT Family Plan <input type="checkbox"/>										I. ID. QUAL. <input type="checkbox"/>										J. RENDERING PROVIDER ID. # <input type="checkbox"/>									
1										2										3										4										5										6																																																	
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. <input type="checkbox"/>										27. ACCEPT ASSIGNMENT? (For go-ins, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ <input type="checkbox"/>										29. AMOUNT PAID \$ <input type="checkbox"/>										30. BALANCE DUE \$ <input type="checkbox"/>																																																	
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.) <input type="checkbox"/>										32. SERVICE FACILITY LOCATION INFORMATION <input type="checkbox"/>										33. BILLING PROVIDER INFO & PH # () <input type="checkbox"/>																																																																															
SIGNED _____										DATE _____										a. <input type="checkbox"/>										b. <input type="checkbox"/>																																																																					

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

KEY

- R** REQUIRED IN FILING A BLUE CROSS CLAIM
- S** SITUATIONAL --- ONLY IF APPROPRIATE TO THIS CLAIM
- NR** NOT REQUIRED/NOT USED

1. **TYPE OF HEALTH INSURANCE COVERAGE** **R**
Select "Other" to indicate that you are submitting a Blue Shield claim.
- 1a. **INSURED ID NUMBER** **R**
Enter the subscriber's identification number from their Blue Cross and Blue Shield ID card.
2. **PATIENT'S NAME** **R** Last name, First name, Middle initial
Enter the patient's last name, first name and middle initial. If patient has suffix, enter after the last name, i.e., Doe Jr, John J
3. **PATIENT'S BIRTH DATE/SEX** **R**
Enter the patient's date of birth using the eight-digit date format (MM/DD/CCYY).
Next, select the patient's gender.
4. **INSURED'S NAME** **R** Last name, First name, Middle initial
Enter the insured's last name, first name and middle initial.
5. **PATIENT'S ADDRESS/TELEPHONE NUMBER** **R**
Enter the patient's permanent mailing address and telephone number.
6. **PATIENT'S RELATIONSHIP TO THE INSURED** **R**
Select the appropriate box for patient's relationship to the insured person.
7. **INSURED'S ADDRESS/TELEPHONE NUMBER** **S**
Enter the insured person's permanent mailing address (complete if different from the patient's address)
8. **PATIENT STATUS** **R**
Select the appropriate box to indicate the patient's status.
9. **OTHER INSURED'S NAME** **S**
Enter the other insured person's last name, first name and middle initial. When the patient has other insurance coverage, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.
- 9a. **OTHER INSURED'S POLICY OR GROUP NUMBER** **S**
Enter the other insured person's policy or group number. (Do not use punctuation.)
- 9b. **OTHER INSURED'S DATE OF BIRTH AND SEX** **S**
Enter the other insured person's date of birth in an eight-digit date format (MM/DD/CCYY).
- 9c. **EMPLOYER'S NAME OR SCHOOL NAME** **S**
Enter the other insured person's employer or school name.
- 9d. **INSURANCE PLAN NAME OR PROGRAM NAME** **S**
Enter the name of the other insured person's insurance plan or program name.
- 10a-d. **IS PATIENT'S CONDITION RELATED TO:**
For 10a – 10d, required status is contingent upon a definitive "Yes" or "No" answer. If you are unsure, leave blank.
10a. Select whether the patient's condition is related to employment. **S**
10b. Select whether the patient's condition is related to an auto accident and enter the state in which the accident occurred. Use two-character abbreviation, i.e. OK. **S**
10c. Select whether the patient's condition is related to any other type of accident. **S**
10d. Not required in filing Blue Shield claims. **NR**
(11 thru 11d, refer to BCBS subscriber coverage)
11. **INSURED'S POLICY GROUP OR FECA NUMBER** **R**
Enter the subscriber's group number from their Blue Cross and Blue Shield I.D. card.
- 11a. **INSURED'S DATE OF BIRTH, SEX** **R**
Enter the subscriber's date of birth using the eight-digit date format (MM/DD/CCYY) and select the subscriber's gender.
- 11b. **EMPLOYER'S NAME OR SCHOOL NAME** **NR**
Enter the subscriber's employer or school name.
- 11c. **INSURANCE PLAN NAME OR PROGRAM NAME** **R**
Enter the subscriber's insurance plan name, include name of state, i.e., Blue Cross and Blue Shield of OK.
- 11d. **IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN** **R**
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9a through 9d. This information is necessary to coordinate benefits with other insurance companies.
12. **PATIENT OR AUTHORIZED PERSON'S SIGNATURE** **NR**
Not required in filing Blue Shield claims.
13. **INSURED OR AUTHORIZED PERSON'S SIGNATURE** **NR**
Not required in filing Blue Shield claims.
14. **DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY** **R**
Enter the date using an eight-digit date format (MM/DD/CCYY).
15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE** **S**
Enter the date using an eight-digit date format (MM/DD/CCYY).
16. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** **S**
Enter the date using an eight-digit date format (MM/DD/CCYY).
17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE** **S**
Enter the referring, ordering or supervising provider's first name, middle initial, last name and credentials. This field is required only if there is a referring, ordering or supervising provider.
- 17a. **OTHER ID#** **NR**
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).
- 17b. **NPI #** **S**
Enter the 10-digit NPI number of the referring, ordering or supervising provider.
18. **HOSPITAL DATES RELATED TO CURRENT SERVICES** **S**
Enter the hospital dates using an eight-digit date format (MM/DD/CCYY).
19. **RESERVED FOR LOCAL USE** **NR**
Not required in filing Blue Shield claims.
20. **OUTSIDE LAB/CHARGES** **R**
Select "Yes" or "No" to indicate if the claim includes charges for lab services performed outside of the physician's office. If Yes, enter the total charges.
21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** **R**
Enter the ICD-9-CM codes. The primary diagnosis should be entered first, followed by other diagnoses if applicable. Up to three additional ICD-9-CM codes can be entered.
22. **MEDICAID RESUBMISSION CODE** **NR**
Not required in filing Blue Shield Claims.
23. **PRIOR AUTHORIZATION NUMBER** **NR**
Not required in filing Blue Shield Claims.
24. **SHADED AREA – SUPPLEMENTAL INFORMATION –**
The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee's Web site at www.nucc.org.
- 24a. **DATE(S) OF SERVICE** **R**
Enter the dates of service using an eight-digit date format (MM/DD/CCYY).
- 24b. **PLACE OF SERVICE** **R**
Enter the appropriate two-digit Place of Service code.
- 24c. **EMG** **S**
If this service was an emergency, enter "Y" for "Yes," or leave blank if "No".
- 24d. **PROCEDURES, SERVICES, OR SUPPLIES** **R**
Enter the CPT or HCPCS code for the procedures, services or supplies, and enter a modifier if applicable.
- 24e. **DIAGNOSIS POINTER** **R**
Enter the appropriate ICD-9-CM diagnosis code or codes for each procedure performed. Enter one code per line of service.
- 24f. **CHARGES** **R**
Enter the charge for each line of service. Do not include discounts.
- 24g. **DAYS OR UNITS** **R**
Enter the number of days or units for each line of service.
- 24h. **EPSDT/FAMILY PLAN** **S**
If applicable, enter the appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) code or family planning (FP) code.
- 24i. **ID QUALIFIER - SHADED FIELD** **NR**
Not required, reserved for taxonomy code qualifier, "ZZ."
- 24j. **RENDERING PROVIDER ID. #**
SHADED FIELD **NR**
Not required, reserved for taxonomy code.
- NON-SHADED FIELD** **R**
Enter the performing provider's 10-digit NPI number in the non-shaded area.
25. **FEDERAL TAX I.D. NUMBER** **R**
Enter the Federal Tax I.D. Number for the provider of service. Select the appropriate field for SSN or EIN.
26. **PATIENT ACCOUNT NUMBER** **S**
Enter account number assigned to the patient, if applicable.
27. **ACCEPT ASSIGNMENT** **R**
Select "Yes" if the provider should be paid, or select "No" if the patient should be paid.
28. **TOTAL CHARGE** **R**
Enter the total charge for all services (total of all charges in 24f).
29. **AMOUNT PAID** **S**
Enter any amount paid by the patient only. Do not enter any amount by Medicare or other insurance.
30. **BALANCE DUE** **S**
Enter the difference, if any, between the total charge and the amount paid.
31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS** **R**
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated, using an eight-digit date format (MM/DD/CCYY).
32. **SERVICE FACILITY LOCATION INFORMATION** **S**
Enter the location where the services were rendered. The provider of service must identify the supplier's information when billing for purchased diagnostic tests.
Note: Per the NUCC Instruction Manual, Field 32 is required if Field 20 is checked "yes."
For more information, see the National Uniform Claim Committee's Web site at www.nucc.org.
- 32a. **NPI** **S**
Enter the 10-digit NPI number of the service facility location.
- 32b. **OTHER ID#** **S**
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).
33. **BILLING PROVIDER INFO AND PH#** **R**
Enter the information of the billing provider or supplier to be paid for services.
- 33a. **NPI** **R**
Enter the 10-digit NPI number of the billing provider.
- 33b. **OTHER ID #** **S**
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17-19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

Note: For more information on Place of Service Codes, see the National Uniform Claim Committee's Web site at www.nucc.org.

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

- 7 Anesthesia information
- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)
- VP Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard
- OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
- CTR Contract rate

For additional information for reporting NDC units, see the National Uniform Claim Committee's Web site at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, zip code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in the BCBSOK's system just the way your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

To obtain more information on electronic claim filing, call (800) 746-4614 or log on to www.bcbsok.com.