

## Field Requirements for CMS-1500 Claim Form – New Version For Driscoll Children’s Health Plan STAR and CHIP Members

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Field	Description	Required/Optional	Remarks
Carrier Block (top right)	Carrier Identification	Required	Driscoll Children’s Health Plan PO Box 3668 Corpus Christi, TX 78469-3668 1-877-324-3627
1	Payer Designation	Optional	For STAR claims select “Medicaid.” For CHIP claims select either “other” or “Medicaid”
1a	Insured I.D. Number	Required	Member’s DCHP ID # (aka Medicaid or CHIP ID Number)
2	Patient Name (Last, First, MI)	Required	Enter the name of the patient with commas between fields  <u>Examples:</u> Doe Jr, John, Q Garcia, Mary, A Brown, John
3	Patient’s Birth Date and Sex	Required	Enter patient’s date of birth (MM   DD   CCYY) and check mark appropriate “gender” code.
4	Insured’s Name	Required	For CHIP and STAR the insured name is the same as the Patient Name. If entered, use Last, First, MI format as shown in box 2.
5 line 1	Patient’s Address	Required	Enter the patient’s address
5 line 2	Patient’s City and State	Required	Enter the City and State of the patient. Use 2-digit post office abbreviations for State name.
5 line 3	Patient’s Zip Code and Phone	Zip = Required Phone = Optional	Enter the patient’s zip code and telephone number
6	Patient Relationship to Insured	Optional	If completed, use SELF
7 line 1	Insured’s Address	Optional	For STAR And CHIP this is same as field 5 line 1
7 line 2	Insured’s City and State	Optional	For STAR And CHIP this is same as field 5 line 2
7 line 3	Insured’s Zip Code and Phone	Optional	For STAR And CHIP this is same as field 5 line 3
8	Patient Status	Optional	If completed, place an X in the appropriate boxes that describe the patient’s marital status and the patient’s employment or student status.
9	Other Insured’s Name	Situational	If there is other insurance for this claim, enter the name of the insured person.

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9a	Other Insured’s Policy/Group #	Situational	If there is other insurance for this claim, enter the policy and group number.
9b	Other Insured’s DOB and Sex	Situational	If there is other insurance for this claim, enter the date of birth and sex of the insured person.
9c	Other Insured’s Employer or School	Situational	If there is other insurance for this claim, enter the name of the employer or school sponsoring the insurance.
9d	Other Insured’s Insurance Plan Name	Situational	If there is other insurance for this claim, enter the name of the insurance carrier.
10a	Condition Related to Employment	Situational	Check YES or NO if condition treated is related to employment.
10b	Condition Related to Auto Accident	Situational	Check YES or NO if the condition treated is related to an automobile accident.  NOTE: If this is YES, an E-level ICD9 code should be shown in field 21.
10c	Condition Related to Other Accident	Situational	Check YES or NO if the condition treated is related to another type of accident other than an automobile accident.  <b>NOTE: If this is YES, please enter the applicable E-level ICD9 as your last diagnosis code in field 21.</b>
10d	RESERVED FOR LOCAL USE	Not Used	
11	Insured’s Policy/Group Number	Not Used	
11a	Insured’s DOB and Sex	Not Used	
11b	Insured’s Employer or School	Not Used	
11c	Insurance Plan Name or Program Name  <b>Used for Texas Medicaid Benefit Code.</b>	Situational  <b>Please note that this is a non-standard field usage required by Texas Medicaid when applicable to the provider. If a benefit code applies to you, it will have been assigned during your TMHP attestation.</b>	If TMHP has assigned you a Benefit Code that code goes in this space. See Code Set #1 at the end of this document for allowable codes.
11d	Is There Another Health Benefit Plan?	Situational	Check YES or NO with regard to other insurance.

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Field	Description	Required/Optional	Remarks
			If YES is entered, fields 9 through 9d must be completed.
12	Patient’s or Authorized Person’s Signature and Date Signed	Situational	If the patient or authorized guardian/person has authorized release of medical records related to this claim, enter “Signature on File” and the date such signature was obtained.
13	Insured’s Signature	Situational	If the insured assigned benefits to the provider or supplier submitting this claim, enter “ <b>Signature of File</b> ” or “ <b>SOF</b> ” in this space.
14	Date of Illness, Injury or LMP	Situational	If the services are related to an illness or injury, enter the date of onset.  If the services are related to pregnancy, enter the date of the last menstrual period (LMP) as MM   DD   CCYY.
15	Date of Similar or Same Illness	Not Used	
16	Dates Patient Unable to Work	Not Used	
17	Name of Referring Physician	Situational	If the services are being provided as a result of a referral from another provider, enter the name of the referring provider.
17a	ID Number of Referring Physician	Situational	Required when services are related to a referral. TPI # = qualifier <b>ID</b> EIN # = qualifier <b>E1</b> SSN # = qualifier <b>SY</b> License # = qualifier <b>OB</b>
17b	Referring Physician NPI	Situational	Required when services related to a referral.
18	Hospitalization Dates	Situational	Enter from and thru dates in MM   DD   CCYY format
19	RESERVED FOR LOCAL USE	Not Used	<b>SUBJECT TO CHANGE</b>
20	Outside Lab? <b><u>YES/NO</u></b>	Situational	Check YES or NO if lab specimens related to this visit were drawn and sent to an outside lab.
20	Outside Lab? <b><u>CHARGES</u></b>	Not Used	

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Field	Description	Required/Optional	Remarks
21	Diagnosis Codes	Required	Enter up to four (4) ICD9 diagnosis codes applicable to this claim.  <i>Decimal points are pre-printed on the form. Place the digits preceding the decimal to the left of the pre-printed decimal point and place the digits following the decimal to the right of pre-printed decimal point.</i>
22	Medicaid Resubmission Code and ICN	Situational  Required for a resubmitted claims	Enter the ICN from the Driscoll EOP representing the claim that you are re-submitting.
23	Prior Authorization Number	Situational, but is required if obtained	If a DCHP prior authorization or referral number was given for the services, enter that number in this space.
24	<b>Itemized Charges Segment</b>		Enter up to 6 service lines
24A-24G <b>Shaded</b> area	This section is for notes. This area is not generally used by Driscoll Children’s Health Plan in the adjudication of a claim. The provider may provide information as deemed appropriate. See the NUCC specifications published by the AMA.		
24A Unshaded area	Dates of Service	Required	Enter the FROM and THRU dates of service represented by the line item. If the FROM and THRU are the same, only the FROM date is required.  Use format: MM   DD   YY.
24B Unshaded area	Place of Service	Required	Enter the Place of Service Code (see applicable codes in table below on pages 7 and 8)
24C Unshaded area	EMG	Not Used	NOTE: This field used to contain the pre-HIPAA type of service code. Providers may populate this field with TOS code, but it will not be used in the adjudication of the claim, it will be ignored during processing.
24D Unshaded area	Procedure Code and Modifier	Procedure = Required Modifier = Situational	Enter the applicable CPT4 or HCPCS code that best describes the service that was furnished.

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Field	Description	Required/Optional	Remarks
			Up to 4 modifiers may be placed on a charge item. All Medicaid-required modifiers are required as applicable.
24E Unshaded area	Diagnosis Pointer  <b>DO NOT auto-populate this field with 1234. Use only the pointers that apply to the diagnosis codes actually submitted on the claim.</b>	Required	Enter the line number of diagnosis code from box 21 that is related to the service provided.  <u>Examples:</u> 1 12 123 1234
24F Unshaded area	Charges	Required	Enter the dollar amount of the charge
24G Unshaded area	Days or Units	Required	Enter the quantity of service in the <b>non-shaded</b> portion of this box.  <u>Examples:</u> 0.5 1 1.5 2 2.5  <b>NOTES:</b> Behavioral Health providers are permitted to bill in half units. Other providers should bill in whole units.  <b>Anesthesia providers should bill total minutes. DCHP will convert minutes to units by dividing the entered value by 15.</b>
24H	THSteps Flag – <b>SHADED AREA</b>  or  Family Planning Flag – <b>UNSHADED AREA</b>	Situational	<b><u>THSteps Services:</u></b> Enter “Y” in shaded area if line item is related to THSteps services.  <b><u>Family Planning Services:</u></b> Enter “Y” in un-shaded area if line item is related to Family Planning services.  Leave this field blank if the line item is not related to either THSteps or Family

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Field	Description	Required/Optional	Remarks
			Planning.
24I Shaded	ID Qualifier	Required	In the <b>shaded</b> section, use one of the following identifiers: TPI # = qualifier <b>1D</b> EIN # = qualifier <b>E1</b> SSN # = qualifier <b>SY</b> License # = qualifier <b>0B</b>
24I Un-shaded	Pre-printed - NPI	Required	In the <b>un-shaded</b> section the value of NPI is pre-printed. Do not change this code.
24J Shaded	Rendering Provider ID	Required	Enter the applicable identifier that matches the ID qualifier set in the <b>shaded</b> section of 24I.
24J Un-shaded	Rendering Provider NPI	Required	Enter the NPI# for the rendering provider  <b>NOTE:</b> See note under field (33a) below.
25	Federal Tax ID Number	Required	Enter the federal tax identification number of the provider furnishing the service or supply.  Check mark the box to indicate if the code entered in a SSN or an EIN.
26	Patient Account Number	Optional	Enter provider’s internal account number.  If present, this number will be reported back to the provider on the EOP.
27	Accept Assignment	Required	Check YES or NO for whether benefits are assigned to the provider
28	Total Charges	Required	Total amount of charges represented on the claim
29	Amount Paid	Situational	Amount paid by the patient and/or other insurance
30	Balance Due	Situational	Difference between field 28 and field 29
31	Physician or Supplier Signature and Date (NOTE: This is the rendering provider)	Required	<b>Provider Name and Date</b> <i>NOTE: Type the actual name. Do not use Signature on File. Do not use rubber stamp signature. No actual signature is required.</i>

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Field	Description	Required/Optional	Remarks
32	Facility Where Services Provided	Required when different than field 33	Enter the full name and address where services were provided.  <b><u>For example:</u></b> Acme Hospital 123 Main St Anytown, TX 78999
32a	NPI # of Facility Where Services Provided	Situational	Required when services provided at a facility other than the provider’s office or facility.
32b	ID# of Facility Where Services Provided	Situational	Required when services provided at a facility other than the provider’s office or facility.  Use the applicable ID Qualifier shown in field (17a) immediately followed by the ID number itself.  For example: TPI# : <b>1D123456701</b> SSN: <b>SY123456789</b> EIN: <b>E1987654321</b>
33	Billing Provider Name and Address	Required	Enter name and physical address  <b><u>Sample:</u></b> John Doe, M.D. 123 Main St Anywhere, TX 77999
33a	Billing Provider NPI #	Required for paper	NOTE: Claim will reject without NPI#
33b	Billing Provider TPI #	Required for paper	NOTE: Claim rejects without TPI#. Submit the TPI# qualifier of 1D immediately followed by the applicable TPI# of the billing provider.  <b>Example:</b> <b>1D123456701</b>  All billing providers must have a Texas Medicaid TPI#.

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### PLACE OF SERVICE CODES: Field 24B of CMS-1500 Form

POS Code	Description	Detailed Description
00-10	Unassigned	
11	Office	Location other than hospital, skilled nursing facility, military treatment facility, community health center, public health clinic, or intermediate care facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis
12	Home	
13-20	Unassigned	
21	Inpatient Hospital	Inpatient hospital other than an inpatient psychiatric 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	A facility that primarily provides INPATIENT skilled nursing care and related services.
32	Nursing Facility	A facility that primarily provides skilled nursing care to patients who RESIDE at the facility.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility – OTHER THAN THE PATIENT’S HOME – where palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	
41	Ambulance – Land	
42	Ambulance – Air or Water	
43-49	Unassigned	
50	Federally Qualified Health Center (FQHC)	
51	Inpatient Psychiatric Facility	
52	Psychiatric Facility – Partial Hospitalization	
53	Community Mental Health Center	
54	Intermediate Care Facility or Facility for the Mentally Retarded	
55	Residential Substance Abuse Treatment Facility	

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56	Psychiatric Residential Treatment Center		
57-59	Unassigned		
60	Mass Immunization Center		A location where providers administer pneumococcal pneumonia and influenza virus vaccinations.
61	Comprehensive Inpatient Rehabilitation Facility		
62	Comprehensive Outpatient Rehabilitation Facility		
63-64	Unassigned		
65	End-Stage Renal Disease (ESRD) Facility		
66-70	Unassigned		
71	State or Local Public Health Clinic		
72	Rural Health Center (RHC)		
73-80	Unassigned		
81	Independent Laboratory		An independent lab (CLIA-certified or CLIA-waivered) performing diagnostic and clinical tests independent from an institution or physician’s office.
82-96	Unassigned		
97	Non-Public School		
98	Public School		
99	Other Unlisted Facility		Other service facilities not identified above.

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## CODE SETS

### Code Set #1 – Texas Medicaid Benefit Code

Program Description	CODE
Comprehensive Care Program (CCP)	CCP
CSHCN Services Program	CSN
Texas Health Steps (THSteps) Medical	EP1
THSteps Dental	DE1
Family Planning Agencies *	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) Providers	ECI
TB Clinics	TB1

\* Agencies only. Benefit code should not be used for individual family planning providers.

### **Special note to providers of THSteps exams:**

THSteps exam billings MUST show the EP1 benefit code for medical exams using the provider’s NPI number. Failure to show benefit code could result in claim denial. This is particularly applicable to Primary Care Providers, but may pertain to OB/Gyns if they are acting as the members PCP.

### **Change Log:**

Date	Version	Changes
4-21-07jc	1.0	Internal version.
5-17-07jc	1.1	Published DRAFT version of V1.0.
5-27-07jc	1.2	Numerous changes to meet NUCC standards. DRAFT removed. Specific important changes to: 17a, 24a-24g shaded, 24e-24j un-shaded, 32b, 33b.

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