Preface:
The following information will help you understand the Medicare and Medicaid programs, how to become a participating “provider,” work with them, and handle your claims for reimbursement. There is much more information about these programs on the website for the Centers for Medicare & Medicaid Services (CMS) at: http://www.cms.hhs.gov/. We hope this will demystify the programs and process for you to make your practice choices as an art therapist easier.

Angela Foehl, J.D., M.P.H. Director of Public Policy
American Art Therapy Association
August 29, 2011

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MEDICARE & MEDICAID PROGRAMS

What are They?
The Medicare and Medicaid programs are government-funded healthcare programs, under which eligible beneficiaries can receive healthcare services and items, to the extent that coverage allows under each program. Medicare is a strictly federally-funded and overseen program. Medicaid is a state program that receives matching federal funds, based upon a federal statutory formula and depending upon state expenditures for the program. State Medicaid programs are administered by state departments of health but are also under federal oversight by the Centers for Medicare & Medicaid Services (CMS).

The Medicare and Medicaid programs reimburse healthcare providers for services they provide to beneficiaries, if the programs cover those services and all criteria are met. (Details about this are below, under WORKING WITH MEDICARE AND MEDICAID.)

What is CMS?
The Centers for Medicare & Medicaid Services (CMS) is a branch of the U.S. Department of Health and Human Services. CMS is the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state. Additional information regarding CMS and its programs is available at: http://www.cms.hhs.gov/

OVERVIEW – MEDICARE http://www.cms.gov/MedicareGenInfo/

“Medicare has:

Part A Hospital Insurance - Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Prescription Drug Coverage - Most people will pay a monthly premium for this coverage. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.”
Eligibility - Medicare

Medicare eligibility is not resource-based; it is age and disability-based. Medicare is a health insurance program for three basic, eligible groups:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Related Links Inside CMS

- Medicare Web site
- Beneficiary Notices Initiatives (BNI)
- Medicare Approved Facilities
- Medicare Health Support
- Medicare Modernization Update
- Telehealth

OVERVIEW – MEDICAID  
http://www.cms.gov/MedicaidGenInfo/

“Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to you; instead, it sends payments directly to your health care providers. Depending on your state’s rules, you may also be asked to pay a small part of the cost (co-payment) for some medical services.

Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services. Read more about your state Medicaid program. (See Related Links inside CMS at the bottom of the page.)

Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These may include your age, whether you are pregnant, disabled, blind, or aged; your income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether you are a U.S. citizen or a lawfully admitted immigrant. The rules for counting your income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home.

Your child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if you are not (however, there is a 5-year limit that applies to lawful permanent residents). Eligibility for children is based on the child's status, not the parent's. Also, if someone else's child lives with you, the child may be eligible even if you are not because your income and resources will not count for the child.

In general, you should apply for Medicaid if your income is low and you match one of the descriptions of the Eligibility Groups. (Even if you are not sure whether you qualify, if you or someone in your family needs health care, you should apply for Medicaid and have a qualified caseworker in your state evaluate your situation.)

Screening Tools
To help you see if you may be eligible for a variety of governmental programs, you may access the GovBenefits and BenefitsCheckUp websites. (See related links inside CMS at the bottom of the page.)”
Eligibility - Medicaid
Medicaid eligibility is partially resource-based and covers various vulnerable populations.

When Eligibility Starts
“Coverage may start retroactive to any or all of the 3 months prior to application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person’s circumstances change. Most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No Federal funds are provided for State-only programs.

What is Not Covered
Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the designated eligibility groups. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds. As noted earlier, categorically needy persons who are eligible for Medicaid may or may not also receive cash assistance from the TANF program or from the SSI program. Medically needy persons who would be categorically eligible except for income or assets may become eligible for Medicaid solely because of excessive medical expenses.”

Downloads
Report on Medicaid Benchmark Plans (Section 1937) [PDF, 61 KB]

Related Links Inside CMS
Medicaid Data Sources - General Information
Medicaid Eligibility

WORKING WITH MEDICARE & MEDICAID
A Medicare or Medicaid “provider” of healthcare services can be either be an individual person or a facility. A “provider” must be “enrolled” in the respective program, meaning that the provider has entered into a contractual relationship with that program. The provider agrees to be legally bound by the program’s fee schedule and abide by other terms. The enrolled provider will bill Medicare or Medicaid directly for services rendered. Physicians, non-physician practitioners, and other health care suppliers must enroll in the Medicare program to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries.

Providers who are not enrolled can still provide services to program beneficiaries under certain conditions, such as if they are under the supervision of an enrolled provider as an employee. However, they cannot be paid directly by those programs. The other requirement to bill Medicare or Medicaid is that the provider must have a National Provider Identifier (NPI) number to use on reimbursement claim forms that will track data.
Enrollment as a Healthcare Provider – Medicare
CMS has established Internet-based Provider Enrollment, Chain and Ownership System (PECOS) as an alternative to the paper (CMS-855) enrollment process. Internet-based PECOS will allow physicians, non-physician practitioners and provider and supplier organizations to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on status of a Medicare enrollment application via the Internet. For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Provider Enrollment & Certification

- Medicare Provider-Supplier Enrollment
- Enrollment Applications
- Accreditation
• Internet-based PECOS
• Ordering Referring Report
• Taxonomy
• Provider Enrollment Regulation

Medicare Fee-for-Service Provider Enrollment Contact List 8/17/2011 (By State)  

Medicare operations are managed by independent contractors known as fee-for-service contractors. The Medicare fee-for-service contractor serving your State or jurisdiction will answer your enrollment questions and process your enrollment application.

An A/B MAC or carrier processes enrollment applications submitted by physicians, non-physician practitioners, and the following organizations:

• Ambulance Service Supplier
• Independent Diagnostic Testing Facility
• Ambulatory Surgical Center
• Mammography Center
• Clinics & Group Practices
• Portable X-ray Supplier
• Independent Clinical Laboratory
• Radiation Therapy Center

Note: If your supplier type is not shown above, contact the designated carrier before you submit an enrollment application.

An A/B MAC or fiscal intermediary processes enrollment applications submitted by the following health care organizations:

• Community Mental Health Center
• Histocompatibility Laboratory
• Organ Procurement Organization
• Comprehensive Outpatient Rehab Facility
• Home Health Agency (HHA)
• Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services
• Critical Access Hospital
• Hospice
• Religious Non-Medical Health Care Institution
• End-Stage Renal Disease Facility
• Hospital
• Rural Health Center
• Federally Qualified Health Center
• Indian Health Services Facility
• Skilled Nursing Facility
Note: If your provider or supplier type is not shown above, contact the designated fiscal intermediary before you submit an enrollment application.

### Medicare Enrollment Applications

An art therapist who has a solo practice or works as an independent contractor should use this form to enroll as the Medicare provider: **CMS 855I--Medicare Enrollment Application for Physicians and Non-Physician Practitioners**.

An art therapist who owns a clinic or group practice that will bill Medicare directly (and to which Medicare payments will be made) should use this form to enroll the clinic or group practice as the Medicare provider: **CMS 855B--Medicare Enrollment Application for Clinics, Group Practices**.

The Medicare enrollment application (CMS-855 or Internet-based Provider Enrollment, Chain and Ownership System (PECOS)) is an Office of Management and Budget approved form and is available in PDF fillable format. This format allows a user to complete an application using Adobe Acrobat and save this information on their personal computer or download the application.

To access the applications, please use indicated links or refer to the [All CMS Forms](#) link, below.

1. **CMS 855A--Medicare Enrollment Application for Institutional Provider** [GET FORM HERE](#) CMS 855A
2. **CMS 855B--Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers** [GET FORM HERE](#) CMS 855B
3. **CMS 855I--Medicare Enrollment Application for Physicians and Non-Physician Practitioners** [GET FORM HERE](#) CMS 855I
4. **CMS 855R--Medicare Enrollment Application for Reassignment of Medicare Benefits** [GET FORM HERE](#) CMS 855R

**Related Links Inside CMS** [Provider/Supplier Enrollment Overview](#)

**Related Links Inside CMS** [All CMS Forms](#)

**Browse by Provider Type**

- [All Fee-For-Service Providers](#)
- [Ambulatory Surgical Centers (ASC) Center](#)
- [Critical Access Hospitals Center](#)
- [Federally Qualified Health Centers (FQHC) Center](#)
- [Home Health Agency (HHA) Center](#)
- [Hospice Center](#)
- [Hospital Center](#)
- [Physician Center](#)
- [Practice Administration Center](#)
- [Rural Health Clinics Center](#)
- [Skilled Nursing Facility Center](#)

**Related Links Inside CMS**

- [Frequently Asked Questions](#)
- [National Provider Identifier (NPI)](#)
- [Medicare Learning Network](#)
Enrollment as a Healthcare Provider – Medicaid
Enrollment forms and procedures for Medicaid are found on each state’s Medicaid website, under the state’s health department. Forms and instructions can also be requested by phone; state health departments are in the government listings of the phone book. (See list of State Medicaid Directors, updated August 24, 2011, under “Resources” at the end of this document.)

Enrollment Processing
Medicare operations are managed by independent contractors known as fee-for-service contractors. The Medicare fee-for-service contractor serving your State or jurisdiction will answer your enrollment questions and process your enrollment application. The directory of state contacts can be found in this document http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

Carriers: Medicare operations are managed by independent contractors known as fee-for-service contractors. An A/B MAC or carrier processes enrollment applications submitted by physicians, non-physician practitioners (such as art therapists), clinics & group practices and other organizations. Tips to Facilitate the Medicare Enrollment Process [PDF,34KB]

Fiscal Intermediaries: An A/B MAC or fiscal intermediary processes enrollment applications submitted by the following health care organizations (others listed online):

<table>
<thead>
<tr>
<th>Community Mental Health Center</th>
<th>Home Health Agency (HHA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Outpatient Rehab Facility</td>
<td>Hospice</td>
</tr>
<tr>
<td>Federally Qualified Health Center</td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Indian Health Services Facility</td>
</tr>
</tbody>
</table>

CLAIMS, BILLING & REIMBURSEMENT

NPI Numbers to Bill Medicare, Medicaid
All reimbursement claims forms (CMS-1500) used to bill Medicare or Medicaid for services rendered to beneficiaries require the billing healthcare provider to use the National Provider Identifier (NPI). This is his or her unique identification number. Whichever legal entity (individual sole proprietor, corporation, partnership, etc.) is the “provider” that is enrolled with Medicare or Medicaid must use an NPI number on its claims forms. More information on NPIs is at: National Provider Identifier (NPI)

The “provider” can be an individual, group practice, clinic, hospital or other type of facility. All types of “providers” fall into some category of legal entity, whether as an individual, group practice, clinic, hospital or other. Each type of legal entity can be a “provider” and apply for the NPI, whether as an individual, corporation, partnership, professional corporation, etc.) Private insurance companies now also use this NPI number for provider billing.

It can take months to receive an NPI number, so it is best to apply for one as soon as you plan to see Medicare or Medicaid beneficiaries in your practice. Without the NPI number, your reimbursement claims will not be processed.

How to Apply for an NPI
How can a health care provider apply for and obtain a National Provider Identifier (NPI)?
Published 01/26/2004 12:24 PM  |  Updated 07/08/2011 11:17 AM  |  Answer ID 2626
A health care provider may apply for an NPI in one of three ways:

1. Apply through a web-based application process. The web address to the National Plan and Provider Enumeration System (NPPES) is https://nppes.cms.hhs.gov

2. If requested, give permission to have an Electronic File Interchange Organization (EFIO) submit the application data on behalf of the health care provider (i.e., through a bulk enumeration process). If a health care provider agrees to permit an EFIO to apply for the NPI, the EFIO will provide instructions regarding the information that is required to complete the process.

3. Fill out and mail a paper application form to the NPI Enumerator. Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. This form is now available for download from the CMS website: http://www.cms.gov/cmsforms/downloads/CMS10114.pdf or by request from the NPI Enumerator. Health care providers who wish to obtain a copy of this form from the NPI Enumerator may do so in any of these ways:

   Phone: 1-800-465-3203 or TTY 1-800-692-2326
   E-mail: customerservice@npienumerator.com
   Mail: NPI Enumerator
         P.O. Box 6059
         Fargo, ND  58108-6059

MEDICARE FEE SCHEDULES
Enrolled providers agree to abide by Medicare fee schedules, which set forth the fee amounts set for performance of specific procedures by specific providers.

Reimbursement Claims for Fees – Medicare
Claims for Medicare and Medicaid reimbursement must indicate the fees for which the provider claims reimbursement. The federal government sets Medicare fees for healthcare providers, referred to as a “Fee Schedule” when they are compiled. Each state sets Medicaid fees for healthcare providers, also referred to as a “Fee Schedule.” The fees are generally connected to a specific service, as indicated by a CPT code.

Download
Medicare Fee-For-Service Contact Information [PDF, 63 KB]

Billing with CMS 1500 Form
Enrolled healthcare providers who have performed services for Medicare or Medicaid beneficiaries are paid by submitting claims for reimbursement to the respective programs. The standard claim form is CMS-1500 (version dated 8/05), also used by many private healthcare insurance companies.

[GET FORM HERE:  CMS 1500]  1500 Fact Sheet
The National Uniform Claim Committee (NUCC) has developed a 1500 Reference Instruction Manual detailing how to complete the claim form. The purpose of this manual is to help standardize nationally the manner in which the form is being completed. The NUCC released its annual, updated version of its Manual in July 2011. The current version of the instructions (v 7.0) is here: Version 7.0 7/11

For more information on the 1500 Health Insurance Claim Form Reference Instruction Manual, email info@nucc.org.

MEDICAID FEE SCHEDULES
Current Medicaid fee schedules are posted on each state’s Medicaid website, which can be located simply by using a search engine such as Google to search with key words, i.e., “Alaska Medicaid” to reach the specific website. At the end of this document is a listing of contacts and web links for all states’ health departments, which oversee state Medicaid programs.

CODING FOR CLAIMS REIMBURSEMENT: MEDICARE & MEDICAID
Claim form CMS-1500 requires specific ICD-9-CM and CPT code entries for each patient visit to describe the disease or disorder (ICD-9 Code) for which the client/patient made the visit and the services provided (CPT Code) to assess or treat it. These extensive coding lists can be purchased on CD-ROM or found free online, where free code search engines are also available.

CPT Codes/Relative Value Search
This page gives users of CPT the opportunity to perform 2011 CPT code searches and obtain information about Medicare’s relative value payment amount associated with the codes. Searches can be performed using 5 digit CPT code numbers or key word(s) in the code description.

CPT - Current Procedural Terminology
www.ama-assn.org

ICD-9-CM Codes
The International Classification of Diseases (ICD) is the classification used to code and classify mortality data from death certificates. A related classification, the International Classification of Diseases, Clinical Modification (ICD-9-CM), is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization in the U.S. Volume 3 (procedures) is used in assigning codes associated with inpatient procedures. The ICD-9-CM is based on the ICD but provides for additional morbidity detail and is annually updated.
- ICD-9-CM on CD-ROM
- ICD-9-CM Files via FTP
- ICD-9-CM Addenda, Conversion Table, and Guidelines
- Other Documents
- (CDC)/FTP server
- ICD-9-CM Files via FTP 2010

Other Codes

Code Sets
- Condition Codes
- Provider Characteristic Codes
- Provider Taxonomy Codes

REIMBURSEMENT CLAIMS PROCESS
For information on the Medicare Claims process, see the:
Chapter 12 - Physicians/Nonphysician Practitioners
Table of Contents
(Rev. 2152, 02-15-11); (Rev. 2247, 06-24-11)

APPEALS-DENIED OR UNDERPAID CLAIMS
If reimbursement is denied, the provider is generally informed of the basic reason for the denial. Sometimes, it is a coding error or other mis-entry on the claim form CMS 1500 that can be rectified. Claims may also be denied based on a finding that the service provided [indicated by the CPT Code(s)] did not meet the program’s criteria for “medical necessity” to justify the service being performed in relation to the disease or disorder for which the patient was seen, as indicated by the ICD-9 Code(s) on the claim form. This is a very common reason for a claim denial. Others are that the service provided was not covered in the first place by the program, so the question of “medical necessity” did not arise.

Procedures are available in government-funded programs like Medicare and Medicaid, in which the provider can dispute the denial of a claim by requesting a second-level review, called a “reconsideration” of the first decision or a review on appeal. It is essential to follow all steps and meet all deadlines during this process, or else the case can be significantly delayed or even lost by default.
While it is also possible to sue in court to resolve claim disputes, the court generally requires that all administrative avenues are exhausted first and the cost of this method often outweighs the amount pursued.

There are various free online sources to assist you with handling claims for reimbursement. Some are produced with other healthcare providers in mind, such as physicians, but the principles are virtually the same for anyone’s claims. For instance, publicly available from the American Medical Association’s website are interactive online tools on the claims management revenue cycle:

- Prepare that claim
- Follow that claim
- Appeal that claim

STATE INDEPENDENT REVIEWS OF DENIED OR UNDERPAID CLAIMS
Many states now have independent review boards overseen by the state departments of insurance that review reimbursement and other claims after they have been denied initially and continue to be denied after the insurer’s appeal or reconsideration process is completed. These generally handle private-sector insurance companies’ claims denials, however. Check with your state to see which kinds of claims these reviewers will accept for their review.

FILING COMPLAINTS
If you feel you have been treated inappropriately with regard to the claims and reimbursement process, you can utilize the following tools to identify the proper method for filing a complaint:

- U.S. map with links to State Department of Insurance complaint forms and State Medical Association complaint processes.
- AMA HIPAA Complaint Form
  Use the Health Insurance Portability and Accountability Act (HIPAA) to inform the AMA about health insurers and other payers that are out of compliance with the HIPAA electronic transaction and code set standards.
- AMA Health Plan Complaint Form
  Use this complaint form to let the AMA know about the hassles and unfair business practices you experience in your day-to-day interactions with health insurers.
- Multi-District Litigation settlement compliance dispute process
  Find out how to file a compliance dispute for those insurers that are a part of the multi-district litigation settlement: Aetna, CIGNA, WellPoint/Anthem, Health Net, Humana and Excellus.
List of State Medicaid Directors

**Alabama**
R. Mullins, MD, MPH  
Commissioner  
State of Alabama, Alabama Medicaid Agency  
501 Dexter Avenue, PO Box 5624  
Montgomery, AL 36103-5624  
Phone: (334) 242-5600  
NAMD Region: III

**Alaska**
Kimberli Poppe-Smart  
Medicaid Director  
State of Alaska, Department of Health and Social Services  
3601 C Street, Frontier Building, Suite 902, PO Box 240249  
Anchorage, AK 99524-0249  
Phone: (907) 269-7800  
NAMD Region: I

**Arizona**
Thomas Betlach  
Director  
State of Arizona, Arizona Health Care Cost Containment System  
801 East Jefferson, MD 4100  
Phoenix, AZ 85034  
Phone: (602) 417-4711  
NAMD Region: I

**Arkansas**
Eugene Gessow  
Director  
State of Arkansas, Department of Health and Human Services  
112 West 8th Street, Slot S401  
Little Rock, AR 72201-4608  
Phone: (501) 682-8740  
NAMD Region: III

**California**
Toby Douglas  
Chief Deputy Director, Health Care Programs  
State of California, Department of Health Care Services  
1501 Capitol Avenue, 6th Floor, MS 0000  
Sacramento, CA 95814  
Phone: (916) 440-7400  
NAMD Region: I

**Colorado**
Suzanne Brennan  
Medicaid Director  
State of Colorado, Department of Health Care Policy and Financing; Medicaid & Child Health Plan (CHP+)  
1570 Grant Street  
Denver, CO 80203-1818  
Phone: (303) 866-5920  
NAMD Region: I

**Connecticut**
Mark Schaefer  
Director of Medical Care Administration/State Medicaid Director  
State of Connecticut, Department of Social Services  
Medical Care Administration  
25 Sigourney Street  
Hartford, CT 06106  
Phone: (860) 424-5067  
NAMD Region: I

**Delaware**
Rosanne Mahaney  
Director  
State of Delaware, Department of Health and Social Services  
1901 N. Du Pont Highway, PO Box 906, Lewis Building  
New Castle, DE 19720  
Phone: (302) 255-9535  
NAMD Region: IV

As of August 24, 2011
District of Columbia
Linda Elam
Deputy Director – Medicaid/Medicaid Director
District of Columbia
899 North Capitol Street, NE, Suite 6037
Washington, DC 20002
Phone: (202) 442-9075
NAMD Region: IV

Florida
Roberta Bradford
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308
Phone: (850) 412-4007
NAMD Region: III

Georgia
Jerry Dubberly
Chief Medicaid Division
State of Georgia, Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303
Phone: (404) 651-8681
NAMD Region: III

Hawaii
Kenneth Fink
Medquest Division Administrator
State of Hawaii, Department of Human Services
601 Kamokila Blvd, Room 518, PO Box 700190
Kapolei, HI 96709-0190
Phone: (808) 692-8050
NAMD Region: I

Idaho
Leslie Clement
Administrator
State of Idaho, Department of Health and Welfare
3232 Elder Street
Boise, ID 83705
Phone: (208) 334-5747
NAMD Region: I

Illinois
Theresa Eagleson
Administrator
State of Illinois, Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001
Phone: (217) 782-2570
NAMD Region: II

Indiana
Patricia Casanova
Director of Medicaid
State of Indiana, Family and Social Services Administration
402 West Washington Street, Room W461, MS 25
Indianapolis, IN 46204
Phone: (317) 234-2407
NAMD Region: II

Iowa
Jennifer Vermeer
Medicaid Director
State of Iowa, Department of Human Services
100 Army Post Road
Des Moines, IA 50315
Phone: (515) 256-4640
NAMD Region: II

Kansas
Andrew Allison, PhD
Director, Division of Health Care Finance
State of Kansas, Department of Health and Environment
900 SW Jackson Avenue, Suite 900-N
Topeka, KS 66612
Phone: (785) 368-8162
NAMD Region: II

Barbara Langner
Medicaid Director
State of Kansas, Department of Health and Environment
900 SW Jackson Avenue, Suite 900
Topeka, KS 66612
Phone: (785) 296-3512
NAMD Region: II

As of August 24, 2011
Kentucky

Neville Wise
Acting Commissioner
Commonwealth of Kentucky, Department of Medicaid Services
275 East Main Street, 6 West A
Frankfort, KY 40621
Phone: (502) 564-4321
NAMD Region: III

Louisiana

Don Gregory
Medicaid Director
State of Louisiana, Department of Health and Hospitals
628 North 4th Street
Baton Rouge, LA 70802
Phone: (225) 342-3891
NAMD Region: III

Maine

Stefanie Nadeau
Acting Director
State of Maine, Department of Health and Human Services
221 State Street
Augusta, ME 04333
Phone: (207) 287-2093
NAMD Region: IV

Maryland

Chuck Milligan
Deputy Secretary, Health Care Financing
State of Maryland, Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201
Phone: (410) 767-4135
NAMD Region: IV

Massachusetts

Julian Harris
Medicaid Director
Commonwealth of Massachusetts, Department of Health and Human Services, Office of Medicaid
1 Ashburn Place, 11th Floor, Room 1109
Boston, MA 02108
Phone: (617) 573-1770
NAMD Region: IV

Michigan

Stephen Fitton
Medicaid Director
State of Michigan, Department of Community Health
400 South Pine Street
Lansing, MI 48913
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*As of August 24, 2011*
## Instructions for Completing the CMS-1500 Form

### Completing the CMS-1500 Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Name and Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 1</td>
<td>MEDICARE</td>
<td>Place an “X” in the appropriate box for the type of health insurance applicable to this claim. If the “other” box contains an “X”, complete field 1a with the primary coverage identification number. If secondary coverage, refer to field 9. Mark only one box.</td>
</tr>
<tr>
<td>▲ 1a</td>
<td>Insured’s I.D. number</td>
<td>Enter insured’s ID number as shown on insured’s ID card for the payer to whom the claim is being submitted. Do not include the patient’s two-digit member number at the end of the ID.</td>
</tr>
<tr>
<td>▲ 2</td>
<td>Patient’s name</td>
<td>Enter the patient’s last name, first name, and middle initial as it appears on the ID card.</td>
</tr>
<tr>
<td>▲ 3</td>
<td>Patient’s birth date</td>
<td>Enter the patient’s eight-digit date of birth in (MMDDCCYY) format. Place an “X” in the appropriate box to indicate the patient’s sex. Mark only one box. If gender is unknown, leave blank.</td>
</tr>
<tr>
<td>▲ 4</td>
<td>Insured’s name</td>
<td>Enter insured’s last name, first name, and middle initial.</td>
</tr>
<tr>
<td>▲ 5</td>
<td>Patient’s address</td>
<td>Enter the patient’s address, city, state, zip code and phone number. If the patient’s phone number is unknown, leave blank. Do not use punctuation. Use two-digit state code and, if available, nine-digit zip code.</td>
</tr>
<tr>
<td>▲ 6</td>
<td>Patient relationship to insured</td>
<td>Place an “X” in the box for “self” if the patient is the insured, “spouse” if the patient is the insured’s husband or wife. If none of the above applies, place an “X” to indicate “child” or “other” as applicable. Mark only one box.</td>
</tr>
<tr>
<td>▲ 7</td>
<td>Insured’s address</td>
<td>Enter the insured’s address, city, state, zip code and phone number. Do not use punctuation. If insured’s address or telephone number is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code. Note: For Worker’s Compensation, use address of employer.</td>
</tr>
<tr>
<td>▲ 8</td>
<td>Patient status</td>
<td>Place an “X” in the appropriate boxes. If the patient is a full-time student, complete field 11b if the information is available.</td>
</tr>
<tr>
<td>▲ 9</td>
<td>Other insured’s name</td>
<td>When additional group health coverage exists, enter other insured’s last name, first name, and middle initial. Enter the employee’s group health insurance information for Worker’s Compensation claims.</td>
</tr>
<tr>
<td>▲ 9a</td>
<td>Other insured’s policy or group number</td>
<td>Enter the policy or group number of the other insured as indicated.</td>
</tr>
<tr>
<td>▲ 9b</td>
<td>Other insured’s date of birth</td>
<td>Enter the other insured’s eight-digit date of birth in (MMDDCCYY) format. Place an “X” in the appropriate box to indicate the other insured’s sex. Mark only one box. If gender is unknown, leave blank.</td>
</tr>
<tr>
<td>▲ 10</td>
<td>Employer’s name or school name</td>
<td>Enter the name of the other insured’s employer or school.</td>
</tr>
<tr>
<td>▲ 11</td>
<td>Insurance plan name or program name</td>
<td>Enter the other insured’s insurance plan or program name.</td>
</tr>
</tbody>
</table>
| ▲ 12    | Is patient’s condition related to: | Only one box can be marked per submission.  
  a. Employment (current or previous)  
  b. Auto accident  
  c. Other accident  
  a. Place an “X” in the appropriate box. If “yes”, complete field 14.  
  b. Place an “X” in the appropriate box. If “yes”, indicate state and also complete field 14.  
  c. Place an “X” in the appropriate box. If “yes”, complete field 14. |
<p>| ▲ 13    | Reserved for local use | Not used. |
| ▲ 14    | Insured’s policy group or FECA number | Enter the insured’s policy or group number as it appears on the ID card if present. For Worker’s Compensation, enter the Worker’s Compensation payer claim number if available. |
| ▲ 15    | Insured’s date of birth | If known, enter the insured’s eight-digit date of birth in (MMDDCCYY) format. If insured’s date of birth is unknown, leave blank. Place an “X” in the appropriate box to indicate the insured’s sex. Mark only one box. If gender is unknown, leave blank. |
| ▲ 16    | Employer’s name or school name | Complete if full-time student. Enter the name of the insured’s employer or school. |</p>
<table>
<thead>
<tr>
<th>Field</th>
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</tr>
</thead>
<tbody>
<tr>
<td>11c</td>
<td>Insurance plan name or program name</td>
<td>Enter the insurance plan name or program name of the insured.</td>
</tr>
<tr>
<td>11d</td>
<td>Is there another health benefit plan?</td>
<td>Place an “X” in the appropriate box. If “yes”, complete fields 9a through 9d.</td>
</tr>
<tr>
<td>12 ▲</td>
<td>Patient's or authorized person's signature</td>
<td>Enter “Signature on File”, “SOF” or legal signature. When legal signature, enter date signed.</td>
</tr>
<tr>
<td>13 ▲</td>
<td>Insured's or authorized person's signature</td>
<td>Enter “Signature on File”, “SOF” or legal signature. This authorization will not be honored for in-state non-participating providers.</td>
</tr>
<tr>
<td>14 ▲</td>
<td>Date of current illness, injury, or pregnancy</td>
<td>Enter the first date in six-digit (MMDDYY) or eight-digit (MMDDCCYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the first date. A date is required if injury or emergency.</td>
</tr>
<tr>
<td>15 ▲</td>
<td>If patient has had same or similar illness, give first date</td>
<td>Enter the first date in six-digit (MMDDYY) or eight-digit (MMDDCCYY) format that the patient had the same or similar illness. Previous pregnancies are not a similar illness. Leave blank if unknown.</td>
</tr>
<tr>
<td>16 ▲</td>
<td>Dates patient is unable to work in current occupation</td>
<td>Enter dates patient is unable to work in six-digit (MMDDYY) or eight-digit (MMDDCCYY) format. Leave blank if unknown.</td>
</tr>
<tr>
<td>17 ▲</td>
<td>Name of referring physician or other source</td>
<td>Enter the name of the physician or other source that referred the patient to the billing provider orordered the test(s) or item(s).</td>
</tr>
<tr>
<td>17a ▲</td>
<td>Other ID #</td>
<td>Enter the two-character qualifier and Other ID. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
<tr>
<td>17b ▲</td>
<td>NPI</td>
<td>Enter the ten-digit NPI.</td>
</tr>
<tr>
<td>18 ▲</td>
<td>Hospitalization dates related to current services</td>
<td>Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) using the six-digit (MMDDYY) or eight-digit (MMDDCCYY) format. If not discharged, leave discharge date blank.</td>
</tr>
<tr>
<td>19 ○</td>
<td>Reserved for local use</td>
<td>Not used.</td>
</tr>
<tr>
<td>20 ▲</td>
<td>Outside lab? $Charges</td>
<td>For lab services enter an “X” in Yes if the reported service(s) was performed by an outside laboratory. If yes, enter the purchase price. Enter an “X” in No if outside lab service(s) is not included on the claim.</td>
</tr>
<tr>
<td>21 ▲</td>
<td>Diagnosis or nature of illness or injury</td>
<td>List up to four ICD-9-CM diagnosis codes. Relate lines 1,2,3,4 to lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this box.</td>
</tr>
<tr>
<td>22 ▲</td>
<td>Medicaid resubmission</td>
<td>For Medicaid resubmission claims only. Enter the correct three-digit replacement reason code followed by the 17-digit TCN of the most current incorrectly paid claim. Refer to Medicaid Manual for code list.</td>
</tr>
<tr>
<td>25 ▲</td>
<td>Prior authorization number</td>
<td>Enter the prior authorization or service agreement number as assigned by the payer for the current service.</td>
</tr>
<tr>
<td>24A-24G ▲</td>
<td>Narrative Description</td>
<td>Enter the supplemental information in the shaded section of 24A through 24G above the corresponding service line. If an unlisted code is used, a narrative description must be present.</td>
</tr>
<tr>
<td>24A ▲</td>
<td>Date(s) of service</td>
<td>Enter the six-digit date(s) of service in (MMDDYY) format. If one date of service only, enter that date under From. Leave To blank or re-enter From date. If grouping services, the place of service, procedure code, charge and rendering provider for each line must be identical for that service line. Grouping is allowed only if the number of days matches the number of units in 24G.</td>
</tr>
<tr>
<td>24B ▲</td>
<td>Place of service</td>
<td>Enter the two-digit code from the place of service list in Appendix 2 in the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
<tr>
<td>24C ▲</td>
<td>EMG</td>
<td>EMG means emergency. Enter Y for “Yes” or leave blank for “No”.</td>
</tr>
<tr>
<td>24D ▲</td>
<td>Procedures, services, or supplies</td>
<td>Enter HCPCS Level I codes (CPT), Level II codes (A-DMEPOS) and modifiers. Up to four modifiers may be submitted.</td>
</tr>
<tr>
<td>Field</td>
<td>Name and Number</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>24E △</td>
<td>Diagnosis code</td>
<td>Enter diagnosis pointer(s) referenced in field 21 to indicate which diagnosis code(s) apply to the related HCPCS code. Do not enter ICD-9-CM codes or narrative descriptions in this field. Do not use slashes, dashes, or commas between reference numbers.</td>
</tr>
<tr>
<td>24F △</td>
<td>$ Charges</td>
<td>Enter the charge amount in (Dollars/Cents) format. If more than one date or unit is shown in field 24G, the dollar amount should reflect the TOTAL amount of the services. Do not indicate the balance due, patient liability, late charges/credits or a negative dollar line. Do not use decimals or dollar signs.</td>
</tr>
<tr>
<td>24G △</td>
<td>Days or units</td>
<td>Enter the number of days or units on each line of service. When determining units refer to Appendix 3 in the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
<tr>
<td>24H △</td>
<td>EPSDT</td>
<td>If related to EPSDT enter Y for “Yes” with a valid referral code. If not related to EPSDT enter N for “No”. For a list of valid EPSDT (C&amp;T) referral codes refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
<tr>
<td></td>
<td>Family Planning</td>
<td>If related to Family Planning, enter a Y for “Yes” or leave blank for “No”.</td>
</tr>
<tr>
<td>24I △</td>
<td>ID Qualifier</td>
<td>Enter the two-character qualifier. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
<tr>
<td>24J △</td>
<td>Rendering Provider ID</td>
<td>Enter the Other ID.</td>
</tr>
<tr>
<td>24J △</td>
<td>Rendering Provider ID</td>
<td>Enter the ten-digit NPI.</td>
</tr>
<tr>
<td>25 △</td>
<td>Federal tax ID number</td>
<td>Enter your employer identification number (EIN) and place an “X” in the EIN box. If not available, enter your Social Security Number (SSN) and place an “X” in the SSN box. Only one box can be marked.</td>
</tr>
<tr>
<td>26 △</td>
<td>Patient’s account number</td>
<td>Enter the patient’s account number.</td>
</tr>
<tr>
<td>27 △</td>
<td>Accept assignment?</td>
<td>For patients with Medicare coverage, place an “X” in the appropriate box.</td>
</tr>
<tr>
<td>28 △</td>
<td>Total charge</td>
<td>Enter the sum of the charges in column 24F (lines 1–6). Enter the total charge amount in (Dollars/Cents) format. Do not use negative numbers.</td>
</tr>
<tr>
<td>29 △</td>
<td>Amount paid</td>
<td>Enter payment amount from the patient or other payer. An Explanation of Benefits may be required.</td>
</tr>
<tr>
<td>50 △</td>
<td>Balance due</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>51 △</td>
<td>Signature of physician or supplier including degrees or credentials</td>
<td>Enter the signature of the physician, provider, supplier or representative with the degree, credentials, or title and the date signed.</td>
</tr>
<tr>
<td>52 △</td>
<td>Service facility location information</td>
<td>Enter the name and actual address of the organization of facility where services were rendered if other than box 35 or patient’s home. Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code</td>
</tr>
<tr>
<td>52a △</td>
<td>NPI</td>
<td>Enter the ten-digit NPI.</td>
</tr>
<tr>
<td>52b △</td>
<td>Other ID</td>
<td>Enter the two-character qualifier and Other ID. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
<tr>
<td>53 △</td>
<td>Billing provider info and phone number</td>
<td>Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code Name and address is required. Phone number is not required. If providing a phone number it must be entered in the area to the right of the box title. The area code is entered in parenthesis; do not use a hyphen or space as a separator.</td>
</tr>
<tr>
<td>53a △</td>
<td>NPI</td>
<td>Enter the ten-digit NPI.</td>
</tr>
<tr>
<td>53b △</td>
<td>Other ID</td>
<td>Enter the two-character qualifier and Other ID. For a list of valid two-character qualifiers refer to the Minnesota Standards for the Use of the CMS-1500 Health Insurance Claim Form manual.</td>
</tr>
</tbody>
</table>