To: All WRS Users

From: WRS Revenue Cycle Management Team

Date: 03/14/14

Re: CMS 1500 Version 02/12 Claim Form

WRS Health presents this document in preview of the new CMS1500 Version 02/12 Claim Form. Note that this form is not yet on the WRS System and will be live on **April 1, 2014.** It will replace the current CMS1500 Version 08/05 at that time.

This preview information is meant only to help with the advance preparation of our clients. We encourage everyone to review this document to become familiar with the new form in advance of the forthcoming changes on **April 1, 2014**.

Webinars Scheduled:

As part of this effort to prepare clients of the coming changes, WRS is presenting a series of webinars over the coming weeks:

March 17th, 11am - https://www1.gotomeeting.com/register/131130393

March 19th, 11am - https://www1.gotomeeting.com/register/731328208

March 21st, 2pm - https://www1.gotomeeting.com/register/809420456

March 24th, 11am - https://www1.gotomeeting.com/register/280198193

March 26th, 1pm - https://www1.gotomeeting.com/register/249054392

March 28th, 3pm - https://www1.gotomeeting.com/register/620968000

CMS 1500 Version 02/12 - Form Changes

We advise all users to review these notes, attend upcoming webinars and visit: http://www.nucc.org/images/stories/PDF/understanding_the_changes_to_the_0212_1500_claim_form.pdf for additional details. Click Here to view a sample of the new form and instructions.

Breakdown of Items (also known as "Boxes" in the CMS 1500)

Item Number 14:

Previous Version: **Removed** the **arrow and text** in the right-hand side of the field.

Figure 1: Previous Version 08/05 Item 14

New Version: Changed title to "DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)." Added "**QUAL**." with a dotted line to accommodate a 3-byte qualifier followed by a date

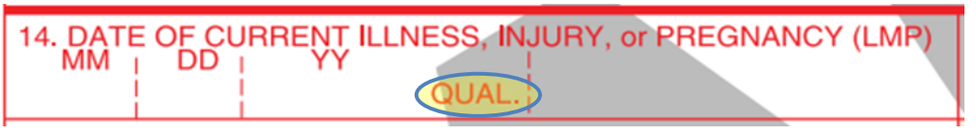

Figure 2: New Version 02/12 Item 14

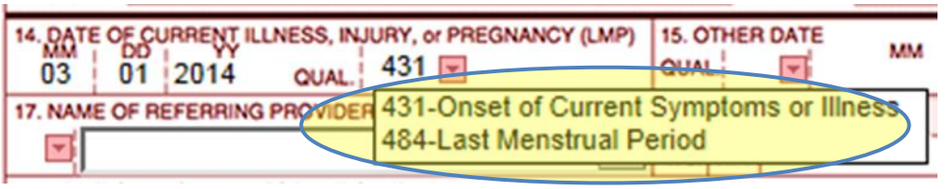

Figure 3: Example Item 14

Item Number 15:

Previous Version: Changed title from "**IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE**" to

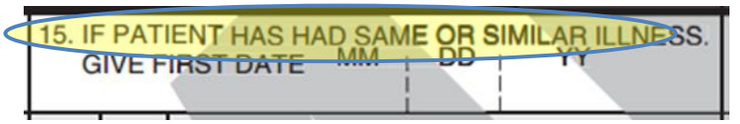

Figure 4: Previous Version 08/05 Item 15

New Version: "**OTHER DATE**." Added "**QUAL**." with two dotted lines to accommodate a 3-by qualifier followed by a date.

Figure 5: New Version 02/12 Item 15

Figure 6: Example Item 14

Item Number 17

Previous Version: Name of Referring Provider or other source.

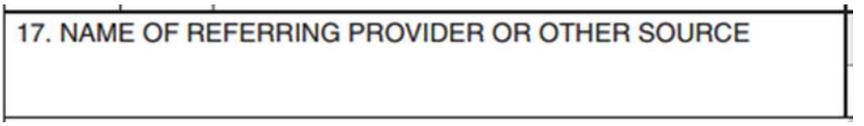

Figure 7 Previous Version 08/05 Item 17

New Version: **Added a dotted line** in the left-hand side of the field to accommodate a 2-byte qualifier followed by provider name.

Figure 8: New Version 02/12 Item 17

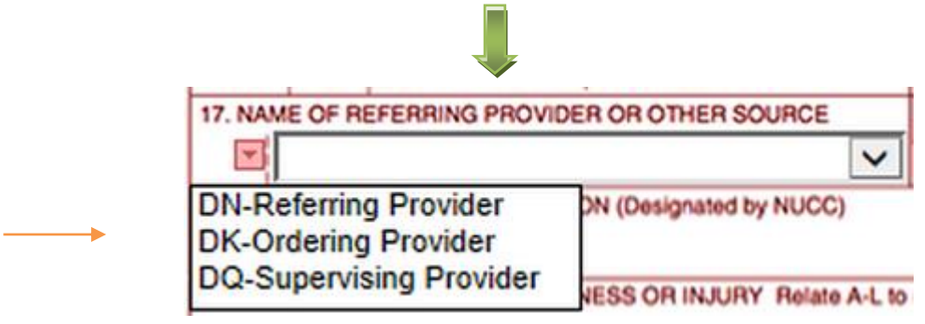

Figure 9: Example Item 17

Item Numbers 21 & 24E

Previous Version: Changed instruction after title from "(**Relate Items 1, 2, 3 or 4 to Item 24E by Line**)" allowed from 4 items

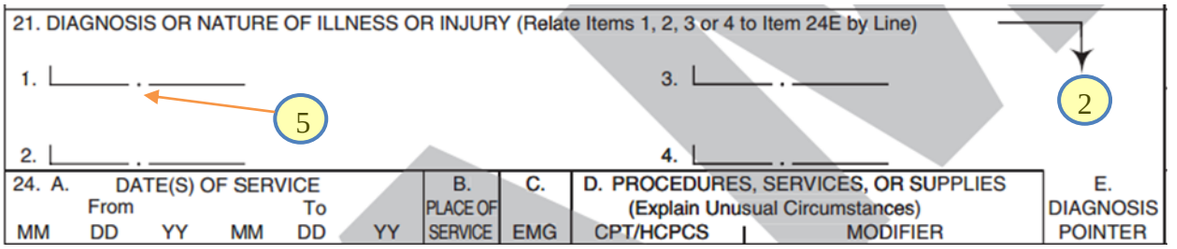

Figure 10 Previous Version 08/05 Items 21 & 24E

New Version:

1. Changed title to "**Relate A-L to service line below (24E)**."
2. Removed **arrow** pointing to 24E
3. Added **8 additional lines for diagnosis codes**. Evenly spaced the diagnosis code lines within the field.
4. Changed **labels of the diagnosis** code lines to **alpha characters** (A – L).
5. Removed the **period** within the diagnosis code lines.

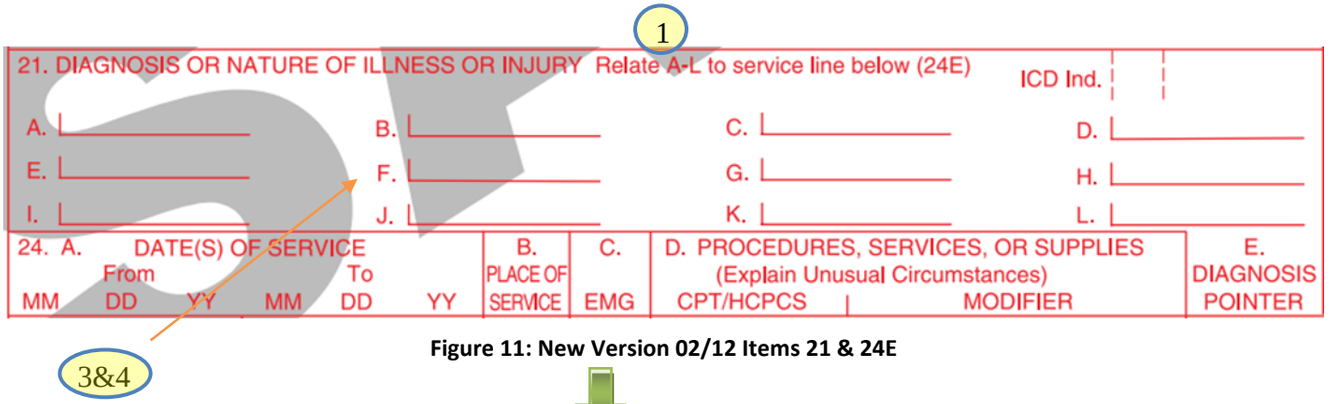

Figure 11: New Version 02/12 Items 21 & 24E

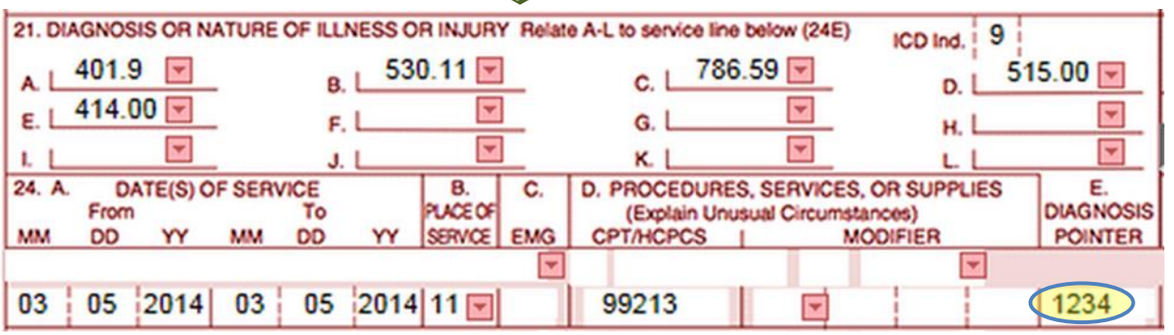

Figure 12: Example Items 21 & 24E

***IMPORTANT:* Only Four (4) Diagnosis Codes are allowed per line item**

**CMS 1500 02/12 Print Settings:*

Left: 0.16
Right: 0.2
Top:0.3
Bottom: 0.2
"Shrink-to-fit-setting UN-chekced

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

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.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS,SEE SEPARATE INSTRUCT10NS ISSUED BY APPLICABLE PROGRAMS.

NOT1CE: Any parson who knowingly fllaa a slalamanlof claim containing any misrepresentation or any false, lncomplata or misleading Information may be guilty of a criminal act punishable under 1 –and may be subject to civil panaHies.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TAICAAE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the inlonnation provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedicalinlonnation and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim Is made. See 42 CFA 411.24(a). If Item 9 Is completed, the patient's signature aLnhortzes release of the Information to the health plan or agency shown. In Medicare assigned or TAICI\AE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TAICAAE fiscal intennediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-awered services. Coinsurance and the deductible are based upon the charge detennination of the Medicare carrier or TAICI\AE fiscal intermediary if this is less than the charge submitted. TAICI\AE is not a health insurance program bLn makes payment for health benefits provided through certain affiliations with the Uniformed Services. Inlonnation on the patient's sponsor should be provided in those items captioned in "Insured";i.e.,items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNAI\JRE OF PHYSICIAN OR SUPPLIER (MEDICARE,TRICARE, FECA AND BLACK LUNG)

In submtnlng this claim lor payment from faderal funds, I certify that: 1) the Information on this fonn Is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient infonnation required to allow the government to make an inlonned eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions lor payment including bin not limited to the Federalanti-kickback statute and Physician Sell-Referral law (commonly known as Stark law); 5} the services on this fonn were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly pennitted by Medicare or TRICARE; 6} for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1} they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an Integral, although Incidental part of a covered physician service, 3) they must be of kinds commonly furnished In physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TAICAAE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Unlfonned Services or a cMIlan employee of the United States Government or a contract employee of the United States Government, either cMiian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were lor a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this fonn is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential Information to receive payment from Federal funds requested by this fonn may upon conviction be subject to line and Imprtsonment under applicable Federal laws.

NOTICE TO PAT1ENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMAT10N (PRIVACY ACT STATEMENT)

We are aLnhorized by CMS, TRICARE and OWCP to ask you for inlonnation needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect infonnation is in section 205(a}, 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a} and 424.5(a) (6), and 44 USC 3101; 41 CFA 101 et seq and 10 USC 1079
and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The infonnation we obtain to complete claims under these programs is used to identify you and to detennine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and10 insure that proper payment is made.

The infonnation may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federalprogram, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose infonnation aboLn the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses lor infonnation contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, •carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-8, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility lor medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the servicesfsupplies received are aLnhorized by law.

ROUTINE USE(S) - Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICAAEICHAMPVI\; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and indMdual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICI\RE.

DISCLOSURES - Voluntary; however, failure to provide infonnation will result in delay in payment or may result in denialof claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply inlonnation. However, failure to fumish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other Inlonnallon, such as name or claim number, would delay payment of the claim. Failure to provide medical Infonnatlon under FECA could be deemed an obstruction.

IIIs mandatory that you tell us If you know that another party Is responsible for paying lor your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties lor withholding this infonnation.

You should be aware that P.L. 10Q-503, the "Computer Matching and Privacy Protecllon Act of 1988", permits the government to verily Information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERT1FICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Individuals under the State's Title XIX plan and to furnish Information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in lull, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of aLnhorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPUER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecLned under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this infonnation collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the infonnation collection. If you have any comments concerning the accuracy of the time estimate(s} or suggestions for improving this fonn, please write to: CMS, 7500 Security Boulevard, Attn: PAI\ Reports Clearance Officer, Mail Stop C4-26-<15, Baltimore, Maryland 21244-1850. This address is lor comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

1500 Health Insurance Claim Form Change Log
6/17/2013

The following is the list of changes between the 1500 Claim Form 08/05 version and the 02/12 version.

Location	Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code).
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12."
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed "(Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#) under "GROUP HEALTH PLAN."
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER."
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "RESERVED FOR NUCC USE."
Item Number 9b	Deleted "OTHER INSURED'S DATE OF BIRTH, SEX." Changed title to "RESERVED FOR NUCC USE."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "RESERVED FOR NUCC USE."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)."
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "OTHER CLAIM ID (Designated by NUCC)." Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier.
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d."
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier.

Location	Change
Item Number 15	Changed title from “IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE” to “OTHER DATE.” Added “QUAL.” with two dotted lines to accommodate a 3-byte qualifier.
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier.
Item Number 19	Changed title from “RESERVED FOR LOCAL USE” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).”
Item Number 21	Changed instruction after title from “(Relate Items 1, 2, 3 or 4 to Item 24E by Line)” to “Relate A-L to service line below (24E).”
Item Number 21	Removed arrow pointing to 24E.
Item Number 21	Added “ICD Ind.” and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator.
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly spaced the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A – L).
Item Number 21	Removed the period within the diagnosis code lines.
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.”
Item Number 30	Deleted “BALANCE DUE.” Changed title to “Rsvd for NUCC Use.”
Footer	Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”
Back	Updates to the language.

Users can visit http://www.nucc.org/images/stories/PDF/understanding_the_changes_to_the_0212_1500_claim_form.pdf for additional details. Click Here to view a sample of the new form and instructions.