CMS1500 Billing Tips

INSTRUCTION ADVICE FOR COMPLETING THE CMS1500 FORM FOR OREGON WORKERS’ COMPENSATION CLAIMS
1. **Field 1:**

Always mark the "OTHER" box. This informs the insurer that this is a workers' compensation claim.

<table>
<thead>
<tr>
<th>Field 1:</th>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>GROUP HEALTH PLAN</th>
<th>PEGA (SSN)</th>
<th>OTHER</th>
<th>INSURED'S I.D. NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare</td>
<td>Medicare</td>
<td>TRICARE</td>
<td>CHAMPUS</td>
<td>GROUP HEALTH PLAN</td>
<td>PEGA (SSN)</td>
<td>OTHER</td>
<td>INSURED'S I.D. NUMBER</td>
</tr>
</tbody>
</table>

---

www.oregonwcdoc.info  503-947-7606  Page 3 of 30
Field 1a: INSURED'S ID NUMBER:

<table>
<thead>
<tr>
<th>Field 1a: INSURED'S ID NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(For Program Form 1500)</td>
</tr>
<tr>
<td>(For Program Form 1500)</td>
</tr>
</tbody>
</table>

**HEALTH INSURANCE CLAIM FORM**

**Page 4 of 30**

www.oregonwcdoc.info

503-947-7606
Field 1a: INSURED’S I.D. NUMBER:

Put the worker’s SSN here (if known)

1a: Put the worker’s social security number here (if it is known). If worker does not have a SSN put five 9’s (99999) in this box so the insurer knows you didn’t just forget to put it in.

Note: this is different information than what is usually put in this box for a general health/Medicare claim.
Field 4: INSURED'S NAME:
Field 4: INSURED’S NAME:

4. INSURED’S NAME (Last Name, First Name, Middle Initial)
   Put the employer’s name here

7. INSURED’S ADDRESS (No. Street)

4: Put the employer’s name here. For workers’ compensation claims, the “insured” is the employer.
Field 7: INSURED’S ADDRESS:

7. INSURED’S ADDRESS (No., Street)

Put the employer’s address here (include City, State, and Zip Code).

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)

( )

7. Put the employer’s address here; telephone number is also useful but not required.
Field 10: IS PATIENT'S CONDITION RELATED TO:
Field 10: IS PATIENT’S CONDITION RELATED TO:

10: Always check the “YES” box under “a.” EMPLOYMENT? (Current or Previous).”

If the injury was due to an automobile accident, check the “YES” box in “b. AUTO ACCIDENT?”

If the injury was due to an automobile accident, put the state where the automobile accident occurred under “PLACE” in “b.”
11: INSURED’S POLICY GROUP OR FECA NUMBER:

Put the workers’ compensation claim number here (if known).

11: Put the workers’ compensation claim number here (if known).
| Field 11c: INSURANCE PLAN NAME OR PROGRAM NAME: |
Field 11c: INSURANCE PLAN NAME OR PROGRAM NAME:

11c: Put the Workers’ Compensation employer department or division here (if different from box 4).
**Field 17: NAME OF REFERRING PROVIDER:**

<table>
<thead>
<tr>
<th><strong>1500</strong> HEALTH INSURANCE CLAIM FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE ON</strong></td>
</tr>
<tr>
<td><strong>5/95</strong></td>
</tr>
<tr>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
</tr>
<tr>
<td><strong>5. PATIENT'S ADDRESS (Street, City, State, Zip):</strong></td>
</tr>
<tr>
<td><strong>6. PATIENT'S ADDRESS (Street, City, State, Zip):</strong></td>
</tr>
<tr>
<td><strong>7. INSURED'S ADDRESS (Street, City, State, Zip):</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
<tr>
<td><strong>CITY</strong></td>
</tr>
<tr>
<td><strong>DIP CODE</strong></td>
</tr>
</tbody>
</table>

**READ INS PAYS BILL BEFORE COMPLETING & SENDING THIS FORM**

1. PATIENTS OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

2. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

3. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

4. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

5. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

6. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

7. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

8. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

9. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
   Signature of any persons authorized to sign the form is necessary. 
   Use a legible font and sign the name or title of the person signing. 
   The signature should be clear and visible. 

10. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

11. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

13. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

14. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

15. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

16. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

17. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

18. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

19. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

20. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

21. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

22. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

23. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

24. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

25. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

26. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

27. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

28. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

29. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

30. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE: 
    Signature of any persons authorized to sign the form is necessary. 
    Use a legible font and sign the name or title of the person signing. 
    The signature should be clear and visible. 

NDOC Instruction Manual available at: www.nmu.org

APPROVED OMB-0680-0999 FORM CMS-1500 (00-05)
Field 17: NAME OF REFERRING PROVIDER:

<table>
<thead>
<tr>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put the name of the Referring Provider here</td>
</tr>
</tbody>
</table>

17: Put the name of the referring provider here.
Fields 17a & 17b: REFERRING PROVIDER'S NPI and TAXONOMY CODE:

<table>
<thead>
<tr>
<th>NPI</th>
<th>17a</th>
<th>17b</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NJCOC Instruction Manual available at: www.njoc.org  
APPROVED OMB-0601-0999 FORM CMS-1500 (08-05)
Fields 17a & 17b: REFERRING PROVIDER’S NPI and TAXONOMY CODE:

When using the taxonomy code, put the required “ZZ” qualifier here.

17a: Put the referring provider’s taxonomy number here. Put “ZZ” as the qualifier when using the referring provider’s taxonomy number.

17b: Put the referring provider’s NPI number here.

**Note:** If you do not have the referring provider’s NPI number, do not report the provider’s taxonomy number.

If the referring provider doesn’t have an NPI, put the referring provider’s state license number in box 17a. Put “0B” as the qualifier in this field when using the provider’s state license number.
Field 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

<table>
<thead>
<tr>
<th>1500 HEALTH INSURANCE CLAIM FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVED BY NATIONAL, UNIFORM CLAIM COMMITTEE (OWG)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read Items 1, 2, 3 or 4 to Index 24A by Line)</td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

www.oregonwcdoc.info 503-947-7606
Page 20 of 30
Field 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

21: Each space must be completed with a correct ICD-9-CM code. Use the ICD-9-CM, 9th Revision book for codes and all applicable digits.

Note: If the 5th digit applies, you must use it here.

Examples from the ICD-9-CM book:

922.3
922 - contusion of the trunk
.3 - contusion of the back (more specific)

722.51
722 - intervertebral disc disorders
.5 - degeneration of thoracic or lumbar intervertebral disc
.51 - thoracic or thoracolumbar intervertebral disc
Field 24: specifically 24J: RENDERING PROVIDER I.D. NUMBER:

[Health Insurance Claim Form with redactions for privacy]
Field 24: specifically 24J: RENDERING PROVIDER I.D. NUMBER:

Put the rendering NPI number here

24J: In the upper shaded box put the rendering taxonomy number. Use “ZZ” as the qualifier in box 24I.
Put the NPI number in the NPI box.

Note: If no NPI number is available for rendering provider, do not use the taxonomy number. Put the rendering provider’s state license number in the upper shaded box of 24J and use “0B” in box 24I for the qualifier.
Field 25: FEDERAL TAX I.D. NUMBER:

(Billing provider’s SSN or FEIN.)
Field 25: FEDERAL TAX I.D. NUMBER:

25: Put the Federal Tax I.D. number of the billing provider (the one being paid) here.
Field 32: (specifically 32a and 32b) SERVICE FACILITY LOCATION INFORMATION:

32a. Put the service facility’s NPI number.
32b. Put the service facility’s taxonomy code. Use “ZZ” as the qualifier ahead of the taxonomy code.

Note: If you do not use the service facility’s NPI number, do not use the taxonomy code. Put the state license number in box 32b. Use “0B” as the qualifier ahead of the state license number.
Field 33: (specifically 33a & 33b) BILLING PROVIDER INFO & PH#:

33a. Put the billing provider’s NPI number.
33b. Put the billing provider’s taxonomy code. Use “ZZ” as the qualifier ahead of the taxonomy code.

Note: If you do not use the billing provider’s NPI number, do not use the taxonomy code. Put their state license number in box 33b. Use “0B” as the qualifier ahead of the state license number.
CMS1500 Billing Tips

RESOURCES

CMS1500 form information:

1) For information on the CMS 1500 form, go to the Centers for Medicare & Medicaid Services (CMS) Web site @

http://www.cms.hhs.gov/CMSForms/
  Click on CMS Forms in the Overview Box, and go to CMS1500 form

2) For instructions on the CMS 1500, go to the National Uniform Claim Committee’s Web site @ www.nucc.org. The NUCC regularly updates this site for revisions to the CMS 1500 instructions.

Workers’ Compensation Division:

1) Medical Section, Resolution Team: 503.947.7606
  Or toll free @ 1.800.452.0288, ask for the Medical Section, Resolution Team

2) Employer Compliance Unit: 503.947.7815 in Salem
  Or toll free @ 888.877.5670

Workers’ Compensation Division’s Web site @

www.wcd.oregon.gov  Find WCD’s laws and rules on this same site.

For a direct link to the Health Care Provider’s page, go to
www.oregonwcdoc.info

To find the employer’s workers compensation insurance carrier, go to
www.wcd.oregon.gov and click on the “Employer Coverage” link under “Business Tools”