A Helpful Guide to Filling Out The Centers for Medicare and Medicaid Services 1500 Claim Form

UnitedHealthcare Connected™ for MyCare Ohio has created this guide to make it easier for HCBS and Waiver providers to complete the standard Centers for Medicare and Medicaid Services (CMS) 1500 claim form. If you have questions, please send an email to ICDSProvider@uhc.com. Thank you.

Box 1 – Select Medicaid

Box 1A – Member's UnitedHealthcare Community Plan number from ID card

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
☐ (Medicare #)	☒ (Medicaid #)	☐ (Sponsor's SSN)	☐ (Member ID#)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)	

Box 2 – Member's last name and first name

Box 3 – Member's date of birth

Box 4 – Member's name

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
	XX XX XX M ☐ F ☐	

Box 5 – Member's primary address

Box 6 – Self

Box 7 – Member's primary address

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self ☒ Spouse ☐ Child ☐ Other ☐	

Box 21A – Diagnosis – This is the reason the member needs the service (example 300.00)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. ____ . ____ 3. ____ . ____	23. PRIOR AUTHORIZATION NUMBER
2. ____ . ____ 4. ____ . ____	

Box 24A – Dates of service – For every service included on this claim, list each date separately

Box 24B – Place of service – This will most likely be number 12 (member's home)

Box 24D – Procedure code – This is the service that was provided by you to the member

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
XX XX XX	XX XX XX			

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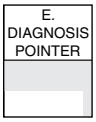
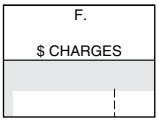
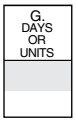
Box 24E – Diagnosis pointer – If only one diagnosis is listed, then an "A" should be entered in this column



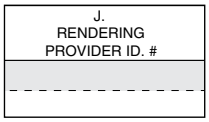
Box 24F – Billed charge – This is the amount that is being billed to UnitedHealthcare Community Plan



Box 24G – Units – this is the number of units that you are billing for – for example if billing T1019 then the number of 15 minute increments is needed



Box 24J – This is the National Provider Identification number (NPI) for the provider who delivered the service/treatment



Box 25 – Federal Tax Id Number – This could also be your Social Security Number

Box 26 – Patient's account number – Not needed

Box 27 – Accept assignment – Check yes

Box 28 – Total charges – This is the sum of all line item charges from 24F 1-6

Box 29 – Amount paid – Enter the total amount paid by the member for services billed on this claim. If your member has an established amount of money that they must pay for their services, and you collect money from your patient for your services, enter that amount here.

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	☐ ☐		☐ YES ☐ NO	$	$	$

Box 31 – Signature of Physician or Supplier – Please sign your name

Box 32 – Can leave blank

Box 33 – Billing provider information – This is your name, address, phone number
Box 33A – Your NPI number

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.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # (XXX) XXX-XXXX
SIGNED DATE	a. NPI	b.	123 Main Street Hometown, ST XXXXX a. b.

You can find more information about UnitedHealthcare Connected for MyCare Ohio, including billing, training, prior authorizations and additional online resources at UHCConnected.com/Ohio.

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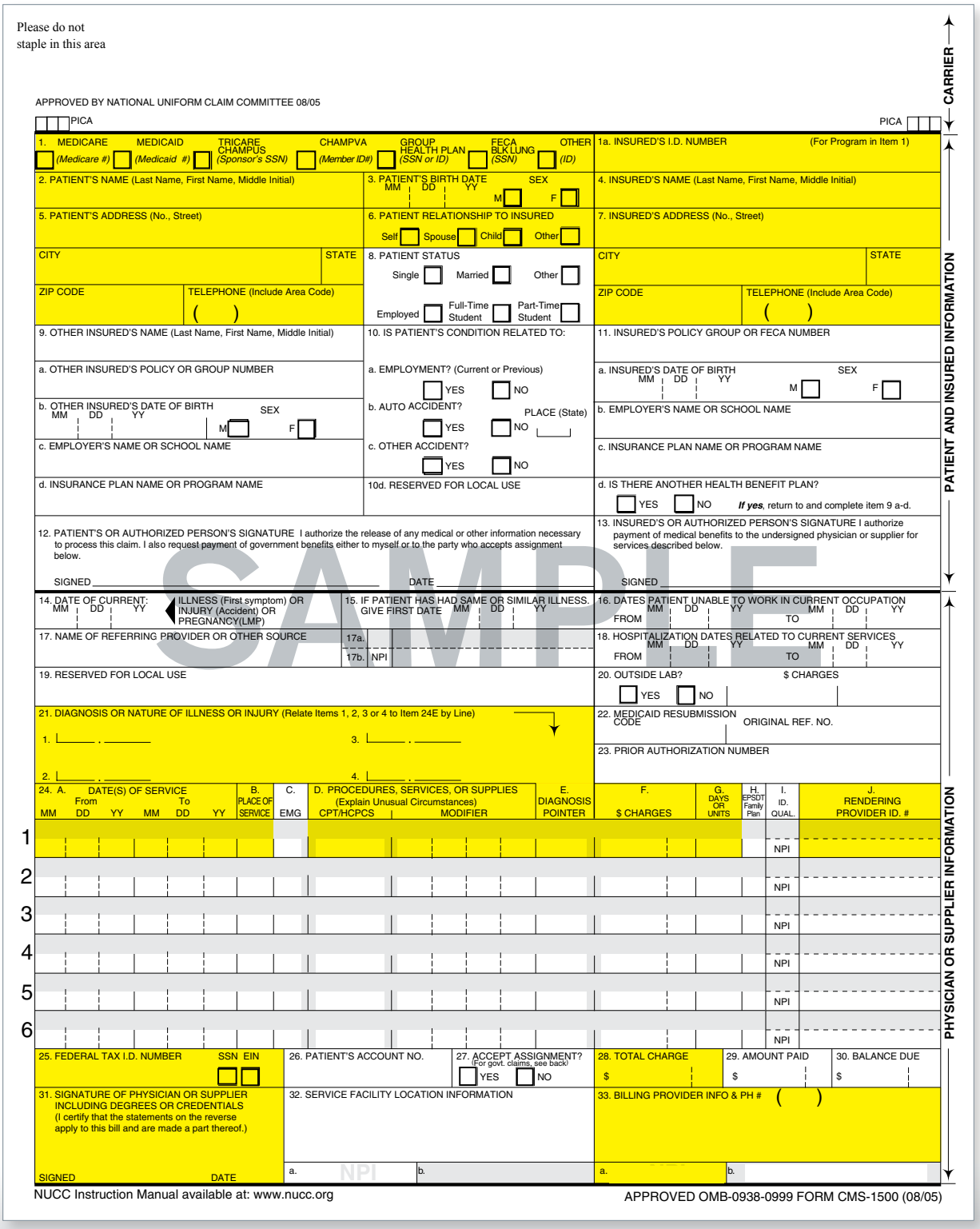
A Helpful Guide to Filling Out The Centers for Medicare and Medicaid Services 1500 Claim Form for Home and Community Based Services Independent Personal Care Aides

We have highlighted the boxes that must be completed before the claim should be submitted.



Please do not
staple in this area

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area 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 SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST 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. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. BALANCE DUE $

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. b.

NUCC Instruction Manual available at: www.nucc.org

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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