


Coach's Corner

Building the CMS 1500 in Chart Talk

Screens used building the 1500

- ▶ Payer Configuration
- ▶ Patient Payer Configuration
- ▶ Location
- ▶ Practice Group
- ▶ Visit
- ▶ User
- ▶ Patient Info



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

MINNESOTA INSURANCE
895 SMALL ROAD
MINNEAPOLIS, MN 55343

PICA PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BENEFIT OTHER 1a. INSURED'S ID. NUMBER (For Program in Item 1) **852465892**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **MILLER, MAX** 3. PATIENT'S BIRTH DATE (MM/DD/YYYY) **01/01/1974** SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) **MILLER, WENDY**

5. PATIENT'S ADDRESS (No. Street) **8500 BIG ROAD** 6. PATIENT RELATIONSHIP TO INSURED Set Spouse Child Other 7. INSURED'S ADDRESS (No. Street) **123 FAKE ST**

CITY **MINNEAPOLIS** STATE **MN** 8. RESERVED FOR NUCC USE CITY **MINNEAPOLIS** STATE **MN**

ZIP CODE **55343** TELEPHONE (Include Area Code) **(952) 374-5550** ZIP CODE **55343** TELEPHONE (Include Area Code) **(123) 456-7513**

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 **55555555**

a. OTHER INSURED'S POLICY OR GROUP NUMBER 10a. EMPLOYMENT? (Current or Previous) YES NO 11a. INSURED'S DATE OF BIRTH (MM/DD/YYYY) **04/01/1970** SEX M F

b. RESERVED FOR NUCC USE 10b. AUTO ACCIDENT? YES NO PLACE (State) **MN** 11b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE 10c. OTHER ACCIDENT? YES NO 11c. INSURANCE PLAN NAME OR PROGRAM NAME **MINNESOTA INSURANCE**

6. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) 11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 **MATT RICHARD** SIGNATURE ON FILE DATE **09/06/2017** SIGNED **MATT RICHARD** SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) (MM/DD/YYYY) QUAL. **09/04/2017** QUAL. **431** 15. OTHER DATE (MM/DD/YYYY) **09/06/2017** 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YYYY) TO (MM/DD/YYYY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a, 17b, 17c, 17d, 17e, 17f, 17g, 17h, 17i, 17j, 17k, 17l, 17m, 17n, 17o, 17p, 17q, 17r, 17s, 17t, 17u, 17v, 17w, 17x, 17y, 17z) **000000000** 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/DD/YYYY) TO (MM/DD/YYYY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CAN ADD WORDS HERE 20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ICD-10 code to service line below (24E) ICD 10 **0** 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. **M99.01** B. **M99.02** C. **M99.03** D. E. F. G. H. I. J. K. L. 23. PRIOR AUTHORIZATION NUMBER

24. A.	DATE(S) OF SERVICE	B.	PLACE OF SERVICE	C.	PROCEDURES, SERVICES, OR SUPPLIES	E.	DIAGNOSIS	F.	G.	H.	I.	J.
MM	DD	YY	MM	DD	YY	EMG	CPT/HCPCS	MODIFIER	\$ CHARGES	ICD 10	REF. NO.	RENDERING PROVIDER ID, #
09	06	2017	09	06	2017	11	99212		20	00	1	NPI 1234567891
09	06	2017	09	06	2017	11	98941		36	00	1	NPI 1234567891
09	06	2017	09	06	2017	11	G8539		0	00	1	NPI 1234567891
09	06	2017	09	06	2017	11						NPI
09	06	2017	09	06	2017	11						NPI
09	06	2017	09	06	2017	11						NPI

25. FEDERAL TAX ID. NUMBER **000000000** SSN EIN 26. PATIENT'S ACCOUNT NO. **M11Ma001** 27. ACCEPT ASSIGNMENT? YES NO 28. TOTAL CHARGE **\$ 56** 29. AMOUNT PAID **\$ 0** 30. REVD FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse side of this claim are made in a true and correct manner.) **MATT RICHARD 09/06/2017** 32. SERVICE FACILITY LOCATION INFORMATION **MINNETONKA Office 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296** 33. BILLING PROVIDER INFO & PH # **MATT RICHARD 13730 ARROWHEAD TRL TEST MINNETONKA MN 234231296**

SIGNED **MATT RICHARD** DATE **09/06/2017** SIGNED **MATT RICHARD** DATE **09/06/2017**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
 PATIENT AND INSURED INFORMATION
 PHYSICIAN OR SUPPLIER INFORMATION

Payer Configuration



HEALTH INSURANCE CLAIM FORM

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

MINNESOTA INSURANCE
895 SMALL ROAD
MINNEAPOLIS, MN 55343

PICA										
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			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	852465892			

Fields Affected

- ▶ Top Address
- ▶ Box 1
- ▶ Box 9d
- ▶ Box 11c
- ▶ Box 19 - IF 'Standard Text' is TRUE claim info value will be included
- ▶ Box 27

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) MILLER, MAX
a. OTHER INSURED'S POLICY OR GROUP NUMBER 95175
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME MEDICA

11. INSURED'S POLICY GROUP OR FECA NUMBER 55555555
a. INSURED'S DATE OF BIRTH MM DD YY 04 01 1970 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME MINNESOTA INSURANCE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize

PATIENT AND INSURED INFO

26. PATIENT'S ACCOUNT NO. MilMa001	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 56 00
32. SERVICE FACILITY LOCATION INFORMATION Minnetonka Office	33. BILLING PROVIDER INFO MATT RICHARD 11730 ARROWHEAD	

LOGIC

- ▶ Box 14 - 'Show Accident Date' set to TRUE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
09 04 2017 431

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CAN ADD WORDS HERE
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Patient Payer Configuration

Fields Affected

- ▶ Box 1a
- ▶ Box 4
- ▶ Box 7
- ▶ Box 9, 9a - When secondary payer exists
- ▶ Box 11, 11a
- ▶ Box 27

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
852465892

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
MILLER, MAX
a. OTHER INSURED'S POLICY OR GROUP NUMBER
95175
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME
MEDICA

7. INSURED'S ADDRESS (No., Street)	
123 FAKE ST	
CITY	STATE
MINNEAPOLIS	MN
ZIP CODE	TELEPHONE (Include Area Code)
55343	(123) 456-7513

11. INSURED'S POLICY GROUP OR FECA NUMBER	
55555555	
a. INSURED'S DATE OF BIRTH	SEX
MM DD YY	M <input type="checkbox"/> F <input checked="" type="checkbox"/>
04 01 1970	
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
MINNESOTA INSURANCE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	

Locations

32. SERVICE FACILITY LOCATION INFORMATION Minnetonka Office 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296	33. BILLING PROVIDER INFO & PH # (234) 234-3342 MATT RICHARD 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296
a. 000001111	a. 000001111

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Fields Affected

- ▶ Box 32 - IsBilling MUST be checked
- ▶ Box 33 - IsService MUST be checked

LOGIC

- ▶ BOX 32a - IF 'Use This' is selected, this NPI will be used over Group or Provider
- ▶ BOX 33a - IF 'Use This' is selected, this NPI will be used over Group or Provider

Group

Logic

- ▶ Box 25 - WHEN provider is a member, Group NPI used here
- ▶ Box 32a - WHEN provider is a member, Group NPI used here OVER provider NPI
- ▶ Box 33a - WHEN provider is a member, Group NPI used here OVER provider NPI

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26
000000000	<input type="checkbox"/> <input checked="" type="checkbox"/>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32

32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (234) 234-3342
Minnetonka Office	MATT RICHARD
11730 ARROWHEAD TRL TEST	11730 ARROWHEAD TRL TEST
MINNETONKA MN 234231296	MINNETONKA MN 234231296
a. 000001111	a. 000001111

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Visit

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										
A.	M99.01	B.	M99.02	C.	M99.03	D.		E.		F.
E.		F.		G.		H.		I.		J.
I.		J.		K.		L.				

Fields Affected

- ▶ Box 21
- ▶ Box 24
- ▶ Box 28
- ▶ Box 31

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	SUPPLIER INFORMATION
	From	To							CPT/HCPCS	MODIFIER								
MM	DD	YY	MM	DD	YY													
1	09	06	2017	09	06	2017	11		99212		ABC	20	00	1		NPI	1234567891	
2	09	06	2017	09	06	2017	11		98941		ABC	36	00	1		NPI	1234567891	
3	09	06	2017	09	06	2017	11		G8539		ABC	0	00	1		NPI	1234567891	

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.)		3
MATT RICHARD	09/06/2017	M
SIGNED	DATE	a

28. TOTAL CHARGE	2
\$ 56.00	
33. BILLING PROVIDER INFO	

LOGIC

- ▶ BOX 10 - IF Visit Type 'isAccident' options for Auto, Work, Other enabled.

If Auto selected, State options enabled

- Box

10. IS PATIENT'S CONDITION RELATED TO:		1
a. EMPLOYMENT? (Current or Previous)		a
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	
b. AUTO ACCIDENT?		b
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO PLACE (State) MN	
c. OTHER ACCIDENT?		c
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	d
10d. CI AIM CODES (Designated by NEICC)		

User Profile

Fields Affected

- ▶ Box 24j
- ▶ Box 31

LOGIC

- ← BOX 32a - This NPI will be used over WHEN not overridden by Group or Location
- ← BOX 33a - This NPI will be used over WHEN not overridden by Group or Location

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER													
1	09	06	2017	09	06	2017	11		99212		ABC	20	00	1		NPI	1234567891
2	09	06	2017	09	06	2017	11		98941		ABC	36	00	1		NPI	1234567891
3	09	06	2017	09	06	2017	11		G8539		ABC	0	00	1		NPI	1234567891

32. SERVICE FACILITY LOCATION INFORMATION Minnetonka Office 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296	33. BILLING PROVIDER INFO & PH # (234) 234-3342 MATT RICHARD 11730 ARROWHEAD TRL TEST MINNETONKA MN 234231296
a. 000001111	a. 000001111

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Patient Info

Fields Affected

- ▶ Box 2
- ▶ Box 3
- ▶ Box 5
- ▶ Box 17 - When referring provider exists AND is selected as main
- ▶ Box 26
- ▶ Box 29 - Sum of payments from Manage Payment screen

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MILLER, MAX		3. PATIENT'S BIRTH DATE MM DD YY 01 01 1974		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 8500 BIG ROAD		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. RESERVED FOR NUCC USE	
CITY		STATE			

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Kirkegaard Soren		17a.	
		17b. NPI	058214569

26. PATIENT'S ACCOUNT NO. MilMa001
29. SERVICE FACILITY LOCATION INF