

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
November 20, 2013
MB# 13-054

MEDICAID BULLETIN

All

TO: Providers Indicated

SUBJECT: Transition to the CMS-1500 Health Insurance Claim Form (02-12) version

In response to guidelines recommended by the National Uniform Claim Committee (NUCC) and set forth by the Centers for Medicare and Medicaid Services (CMS), the South Carolina Department of Health and Human Services (SCDHHS) is implementing the revised CMS-1500 Health Insurance Claim Form (02-12) version effective January 6, 2014.

Although the CMS-1500 form (02-12) is effective January 6, 2014, use of the revised form is optional until March 31, 2014. The transitional dual acceptability period of the current and the revised forms is described as follows:

- January 6, 2014 – March 31, 2014: Providers can use either the current CMS-1500 form (08-05) version or the revised CMS-1500 form (02-12) version.
- April 1, 2014: The current CMS-1500 form (08-05) version is discontinued; only the revised CMS-1500 form (02-12) version is to be used.

Note: *All rebilling of claims should use the revised CMS-1500 form (02-12) version from this date forward, even though earlier submissions may have been submitted on the prior CMS-1500 form (08-05) version.*

With the release of the revised CMS-1500 form (02-12) version, many field names have changed to "Reserved for NUCC Use." The NUCC has provided instructions regarding how to complete the revised CMS 1500 form (02-12) version, but these are not a national mandate. Individual payers are permitted to use the fields on the CMS 1500 form (02-12) versions that best serve their purposes, even if these are different than the text or direction suggested by the NUCC.

For Providers' convenience, SCDHHS has provided multiple means of obtaining completion instructions for the revised CMS-1500 (02-12) version of the claim form.

- Each provider manual on the SCDHHS website (<http://www.scdhhs.gov/provider-manual-list>) will contain field-by-field completion instructions in Section 3, Billing Procedures.
- Educational resources are available on the Healthy Connections Medicaid E-Learning website (<http://medicaidelearning.com>) to assist providers in the use of the revised form.
- A sample of the revised CMS 1500 form (02/12) version is attached to this bulletin for informational purposes only. ***The SCDHHS will not supply the CMS 1500 claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice.***

If you have questions regarding this bulletin or need assistance with completing the form, please contact the SC Medicaid Provider Service Center at 1-888-289-0709. Thank you for your continued support of the South Carolina Healthy Connections Medicaid Program

/s/
Anthony E. Keck
Director

Attachments



DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																								
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)														
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>)										7. INSURED'S ADDRESS (No., Street)														
CITY					STATE					8. RESERVED FOR NUCC USE					CITY					STATE														
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 <input type="checkbox"/> NO <input type="checkbox"/>)					a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)					b. OTHER CLAIM ID (Designated by NUCC)																			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? (YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____)					c. RESERVED FOR NUCC USE					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? (YES <input type="checkbox"/> NO <input type="checkbox"/>)					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.)																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					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.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					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 _____					DATE _____					SIGNED _____					DATE _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL. _____					15. OTHER DATE (MM DD YY) QUAL. _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					17b. NPI _____					20. OUTSIDE LAB? (YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____)																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____														
A. _____		B. _____		C. _____		D. _____		E. _____		F. _____		G. _____		H. _____		I. _____		J. _____		K. _____		L. _____												
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 (CPT/HCPCS MODIFIER)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																
1																																		
2																																		
3																																		
4																																		
5																																		
6																																		
25. FEDERAL TAX I.D. NUMBER					SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (YES <input type="checkbox"/> NO <input type="checkbox"/>)					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.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()														
SIGNED _____					DATE _____					a. NPI _____					b. _____					a. NPI _____					b. _____									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION