CHILDREN WITH MEDICAL HANDICAPS PROGRAM

BILLING INSTRUCTIONS
FOR THE CMS – 1500 (02/12)

Item 1 **PROGRAM**
Check “Other” as the type of health insurance.

Item 1a **INSURED’S I.D. NUMBER**
Enter the 12-digit CMH number.

Item 2 **PATIENT’S NAME**
Enter the patient’s last name, first name and middle initial.

Item 3 **PATIENT’S BIRTHDATE AND SEX**
Leave blank.

Item 4 **INSURED’S NAME**
Leave blank.

Item 5 **PATIENT’S ADDRESS**
Leave blank.

Item 6 **PATIENT’S RELATIONSHIP TO INSURED**
Leave blank.

Item 7 **INSURED’S ADDRESS**
Leave blank.

Item 8 **RESERVED FOR NUCC USE**
Leave blank.

Item 9 **OTHER INSURED’S NAME**
Leave blank.

Item 9a **OTHER POLICY OR GROUP NUMBER**
Leave blank.

Item 9b **DATE OF BIRTH/SEX**
Leave blank.

Item 9c **RESERVED FOR NUCC USE**
Leave blank.

Item 9d **INSURANCE PLAN OR PROGRAM NAME**
Leave blank.

Items 10a-c **IS PATIENT’S CONDITION RELATED TO:**
Check “YES” or “NO” to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Item 24.

Item 10d **CLAIM CODES (Designated by NUCC)**
If you have received payment for the service from a source other than Medicaid or Medicare, please enter the appropriate one-character source code as listed below:

1 = Self/Family
2 = Blue Cross/Blue Shield
3 = Private Carrier
4 = Employer or Union
5 = Public Agency
6 = Other (enter the name and address of the source in the provider remarks section)

If you have not received payment from a third-party insurer, but there are indications of private (non-Medicaid /non-Medicare) health insurance coverage in the case, please enter the appropriate 1-character reason code as listed below:

R — No Response From Carrier. Means no response from the insurance carrier within 90 days from submission of a claim to the insurance carrier. A claim with this code may not be submitted to CMH until 91 days after the date of treatment.

P — No Coverage for this CMH client. Means the provider has confirmed there is health insurance for some members of the client's family, but this particular client is not covered.

F — No Coverage for All Billing Numbers. Means there is no health insurance for any member of the medical assistance group. NOT APPLICABLE FOR CMH CLIENTS.

L — Disputed or Contested Liability. Means that the provider has confirmed there is health insurance, but the coverage for the billed service is disputed or contested by the insurance carrier. Do not use this code when the insurance carrier is requesting additional information.

S — Non-covered Services. Means the provider has confirmed there is health insurance, but the policy does not cover the services being billed. This code should also be used when the amount billed has been applied to the insurance deductible.

E — Insurance Benefits Exhausted. Means the provider has confirmed there is health insurance, but the policy benefits for the billed services have been exhausted.

X — Non-cooperative Recipient. Means the provider has confirmed there is health insurance, but the patient refused to cooperate in collection effort. Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third-party insurer.

If you have not received payment from another source and there is no indication of health insurance coverage for the client, leave this item blank.

Item 11 **INSURED'S POLICY GROUP**
Leave blank.

Items 11 a-d Leave blank.

Item 12 **SIGNATURE**
Leave blank.

Item 13 **SIGNATURE**
Leave blank

Item 14 **DATE OF CURRENT - ILLNESS OR INJURY OR PREGNANCY (LMP)**
Leave blank.

Item 15 **OTHER DATE**
Leave blank.

Item 16 **DATES**
Leave blank

Item 17 **NAME OF REFERRING PHYSICIAN**
Complete only if using 9111115 in Item 17a.

Item 17a **ID OF REFERRING PHYSICIAN**
Leave blank

Item 17b **NPI OF REFERRING PHYSICIAN**
Leave blank

Item 18 **HOSPITALIZATION DATES**
Leave blank.

Item 19 **ADDITIONAL CLAIM INFORMATION (Designated by NUCC)**
This space may be used to clarify information on the invoice.

Item 20 **OUTSIDE LAB**
Leave blank.

Item 21 **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
Enter all the ICD-10 diagnosis codes in order of significance, up to a maximum of four.

Item 22 **MEDICAID RESUBMISSION CODE**
Leave blank. Not applicable to CMH.

Item 23 **PRIOR AUTHORIZATION NUMBER**
Leave blank. Not applicable to CMH.

Item 24 A **DATE(S) OF SERVICE**
Under "From," enter the six-digit dates of service (MMDDYY) in chronological order (first to last). Enter all six digits consecutively without dashes, slashes or spaces. *You do not have to enter a date under "To."* A separate line is required for each date of service. *FAILURE TO ENTER A DATE IN "FROM" COLUMN WILL CAUSE THE LINE ITEM TO REJECT.*

All services must be billed to CMH within 365 days of the date of service.

Item 24 B **PLACE OF SERVICE**
Enter the appropriate place of service from the list below.

11 — Office
12 — Home
21 — Inpatient Hospital
22 — Outpatient Hospital
23 — Emergency Room - Hospital
24 — Ambulatory Surgical Center
25 — Birthing Center
26 — Military Treatment Facility
31 — Skilled Nursing Facility
32 — Nursing Facility
33 — Custodial Care Facility

Item 24 B **PLACE OF SERVICE - continued**

Place of service codes continued:

34 — Hospice
41 — Ambulance - Land
42 — Ambulance - Air or Water
51 — Inpatient Psychiatric Facility
52 — Psychiatric Facility Partial Hospitalization
54 — Intermediate Care Facility/Mentally Retarded
55 — Residential Substance Abuse Treatment Facility
56 — Psychiatric Residential Treatment Center
61 — Comprehensive Inpatient Rehabilitation Facility
62 — Comprehensive Outpatient Rehabilitation Facility
71 — State or Local Public Health Clinic
72 — Rural Health Clinic
73 — Clinic, Not Otherwise specified
81 — Independent Laboratory
99 — Other Unlisted Facility

Item 24 C **EMG**
Leave blank.

Item 24 D **PROCEDURES/SERVICES/SUPPLIES**
Procedure Codes — Enter the appropriate five-character/digit CPT or HCPCS code in the un-shaded area.which corresponds to the service rendered.
For Nutritional Supplements (Enteral Formulas), enter the appropriate CMH NS- code in the shaded area directly above the appropriate five-character/digit HCPCS code entered iin the un-shaded area.

Modifiers — In certain instances, a two-character/digit modifier will be required depending upon the service. When entering a code with a modifier, enter the two-character/digit modifier directly behind the solid hash line using no spaces, dashes or slashes. Use the appropriate modifier as listed below:

Ambulance Service – Use HH with the appropriate five-character procedure code.

Anesthesia — Use AA, AD, QK, QX, QY, QZ with appropriate five-character anesthesia CPT.

Assistant At Surgery — Use 80 with appropriate five-character surgery code.

Bilateral Procedure — Use 50 with appropriate five-character procedure code to indicate a bilateral procedure.

Radiology — Use the appropriate five-character radiology code (70000 thru 79999) to indicate the total procedure.

Use TC with appropriate five-character radiology code to indicate technical component only.

Use 26 with appropriate five-character radiology code to indicate professional component only.

Lab & Test — Use the appropriate five-character Lab & Test procedure (80000 thru 89999) to indicate technical component only.

Use ZP with the appropriate five-character Lab & Test procedure to indicate the total procedure.

Use 26 with the appropriate five-character Lab & Test procedure to indicate the professional component.

Item 24 E **DIAGNOSIS CODE INDICATOR**
Leave blank.

Item 24 F **CHARGES**
Enter your usual and customary fee for the service listed on this line.

Item 24 G. **UNITS**
Enter the number of units of service. For Anesthesia Provider, enter the number of actual anesthesia minutes in the unit field.

Item 24 H **EPSDT/FAMILY PLANNING**
Enter an "E" if the service is a HEALTHCHEK service or a follow-up to a HEALTHCHEK examination. Enter a "F" if the service is related to family planning. Otherwise, leave blank.

Item 24 I **ID QUAL**
Enter the two-digit qualifier "1D" in the red shaded area above "NPI." The qualifier will always be "1D" when submitting claims to CMH.

Item 24 J **RENDERING PROVIDER ID**
Enter the appropriate NPI number in the unshaded area.

Do not submit claims to CMH with multiple rendering providers on a single claim form. Submit a unique claim for each rendering provider, even if the services were rendered by different members of the same group practice (or billing group provider). Claims submitted with multiple rendering providers on a single claim will adjudicate using the first set of provider identifiers (NPI) listed in column 24 J.
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Item 25 **FEDERAL TAX I.D. NUMBER**
Leave blank.

Item 26 **PATIENT'S ACCOUNT NO.**
(Optional) This is for the provider's use in identifying patients and allows use of up to nine numbers or letters (no other characters are allowed.) If used, this number will appear on the remittance advice.

Item 27 **ACCEPT ASSIGNMENT**
Leave blank.

Item 28 **TOTAL CHARGE**
Enter the total charge for all services on this invoice. This number should be the sum of charges in column F.

Item 29 **AMOUNT PAID (AKA OTHER SOURCE)**
Enter the amount collected from all sources.

Item 30 **BALANCE DUE (AKA NET CHARGE)**
Enter the difference between the total charge (Item 28) and the amount received from other sources (Item 29).

Item 31 **SIGNATURE**
Show the signature of the provider or his representative and the date the form was signed.

Item 32 **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**
Leave blank.

Item 33 **BILLING PROVIDER INFO & PH #**

Enter the provider's name, mailing address, city, state, Zip code.

Item 33A **NPI**
Enter the 10-digit NPI as instructed:

When the billing provider is a group practice or billing group, the NPI assigned to the group must be entered in this field. The individual who rendered the service must be identified as instructed in field 24 J. When this field is completed, payment for the billed service(s) will be made to the group instead of the individual provider rendering the service(s).

Item 33B **MEDICAID LEGACY NUMBER**
Leave blank.

MAILING INSTRUCTIONS:

Prepare one copy of the invoice to be retained in your file. Attach an operative report to an invoice for surgical services. Mail the original invoice when completed to:

Children with Medical Handicaps Program
P.O. Box 1603
Columbus, Ohio 43216-1603