Filing Dental Charges on a CMS 1500

The following example represents the minimal information required for filing medical services provided by a dentist on the CMS 1500 claim form.

BlueCross BlueShield Nebraska

HEALTH INSURANCE CLAIM FORM

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

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 Item 1): YEF257148751

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE: 9 22 1965 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

5. PATIENT'S ADDRESS (No., Street): 1717 Mulberry Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY: Anytown | STATE: NE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 68000 | TELEPHONE (Include Area Code): (402) 555-1234

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]

c. OTHER ACCIDENT? YES [X] NO [ ]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: 3 10 1966 SEX: M [ ] F [X]

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Blue Cross Blue Shield of NE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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: Signature on File DATE: 8-11-14

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: Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 8 10 2014 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Splinter in buccal mucosa

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. S01.512A B. C. D.

E. F. G. H.

I. J. K. L.

22. 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	8 11 14		11		D0140		1	55 00			NPI	1223345678
2	8 11 14		11		D7530		1	175 00			NPI	1223345678
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 448227712 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: LJ5012L

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 230 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 230 00

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: Jill Smith DATE: 8/11/14

32. SERVICE FACILITY LOCATION INFORMATION: 123 Main Street, Anytown, NE 68000

a. NPI b.

33. BILLING PROVIDER INFO & PH #: ( ) Acme Dental Clinic, P.O. Box 123, Anytown, NE 68000

a. 199887653 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Box 1a. The member's Blue Cross and Blue Shield I.D. number as it appears on their card. Do not use the member's Social Security number.

Box 2. Patient's full name.

Box 3. Patient's date of birth and sex.

Box 4. Insured's full name. This is the person who is the subscriber on the policy. If patient and insured are the same person, you may put "SAME" in this field.

Box 5. Patient's current address (required) and phone number (optional).

Box 6. Check the appropriate box for patient's relationship to insured.

Box 7. Insured's address. Include if different than patient's address. Put "SAME" if insured and patient live at the same address.

Box 9. If patient is covered under more than one policy, put the secondary policy information here. Otherwise leave blank.

Box 10. If services are due to an accident, check the appropriate box. Otherwise check "NO" on all three boxes.

Box 11. Insured's date of birth and sex. Policy number and insurance name are optional.

Boxes 12 and 13. If patient or insured has signed your clinic's ROI form, then list "Signature on File."

Box 14. For accident claims, list the date of the accident.

Box 19. Medical claims require a diagnosis. Use this field to further explain or specify the reason for treatment. For accident claims, briefly describe accident.

IMPORTANT: for impacted teeth, list "impacted teeth" in this field.

Box 20. Check the "NO" box.

Box 21. For services due to an accident, list diagnosis code SØ1.512A (Laceration without foreign body of oral cavity) OR SØ2.5 (Fracture of Tooth). Remember to include the accident date in Box 14 and the accident description in Box 19. For impacted teeth, list diagnosis code K01.1 (Impacted Tooth).

Box 24 correlates the services rendered. You may list up to six separate procedures.

- **A.** Date of Service when you treated the patient.
- **B.** Place of Service code. For your clinic, use **11**. For outpatient services performed in a hospital, use **22**. For services provided in an Ambulatory Surgery Center (ASC), use **24**.
- **D.** Use the CDT code that best describes the service. You may also use the medical CPT code, if you know it.
- **E.** This field ties the line charge procedure to the appropriate diagnosis in Box 21. If only one diagnosis, always use **1**. If more than one diagnosis, use this field to indicate the diagnosis number that relates to the procedure on the line charge. Enter only one diagnosis reference number per line charge.
- **F.** The billed charges for this procedure.
- **G.** Number of times you performed this procedure.
- **J.** Your rendering or individual NPI number.

Note: Repeat the line charges as necessary.

Box 25. Your clinic's Employer tax I.D. or your Social Security number, depending on how you directed BCBSNE which one to use to reimburse you.

Box 26. Your clinic's patient account number (optional).

Box 27. If you are a BCBSNE PPO provider, always check the "YES" box.

Box 28. Total charge of column 24F.

Box 29. Amount paid by other insurance if you are filing to BCBSNE as secondary. If filing to BCBSNE as primary, it should be $0.

Box 30. Balance for BCBSNE to consider if other insurance paid. Otherwise, it should be the same amount as Box 26.

Box 31. The treating dentist's name and credentials.

Boxes 32 and 33. If the physical address where services were rendered is the same as the payment/remittance in Box 33, then leave Box 32 blank. If the address in Box 33 is a P.O. Box or different than the physical address where services were rendered, then list the physical address in 32. Do not use a P.O. Box in Box 32.

Box 33A. Your clinic or Type 2 NPI (optional).