DSS
Strong Families - South Dakota's Foundation and Our Future

South Dakota DEPARTMENT OF HUMAN SERVICES

HOW TO COMPLETE THE CMS 1500 CLAIM FORM

Assisted Living Providers
Effective for dates of service on or after February 1, 2018

Rev. 1/11/2018

The following is a step-by-step explanation of how to prepare the health insurance claim form, CMS 1500. Failure to properly complete MANDATORY requirements will cause the claim to be denied by South Dakota (SD) Medicaid. If submitting paper claims, please refer to http://dss.sd.gov/medicaid/ocr.aspx for claim form requirements.

BLOCK 1A INSURED'S ID NO. ***(MANDATORY)***
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.

BLOCK 2 PATIENT'S NAME ***(MANDATORY)***
Enter the recipient's last name, first name, and middle initial.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ***(MANDATORY)***

1. Enter 0 for the ICD-10-CM indicator.
2. Enter the codes on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code.

BLOCK 22 RESUBMISSION CODE

1. Enter a 7 for an Adjustment; or an 8 for a Void.
2. List the original reference number found on your remittance advice. This number will always be 14 digits.

Note:
You cannot void or adjust one line on the claim. The void or adjustment will apply to the entire claim.

As of February 1, 2018 you may only void prior submitted UB claims. Once the claim is voided, please resubmit the charges on the CMS 1500 form.

BLOCK 24
Use a separate line for each date span. If billing on paper and more than six date spans were provided in a single calendar month then a separate claim form for the seventh and following services must be completed; continued claims are not accepted. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code.

24A. DATE OF SERVICE FROM – TO *(MANDATORY)*
Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion.

	FROM	TO
Example:	100117	103117

***Hospital reserve bed days*:** An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to SD Medicaid per hospitalization; however, the recipient must return to the ALC for a minimum of 24 hours before additional hospital reserve bed days will be paid. *Hospital reserve bed days must be billed with a code of 21 in 24B for the place of service.*

Therapeutic leave days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Assisted Living Center for non-medical reasons (e.g., visits to the homes of family or friends). *Therapeutic leave days must be billed with a code 12 in 24B for the place of service.*

Note:
Do not include the recipient's date of discharge or date of death in the dates of service.

24B. PLACE OF SERVICE *(MANDATORY)*
Enter the appropriate place of service code.
Code values:
12 Home
13 Assisted Living Center
21 In-Patient Hospital

24D. PROCEDURE CODE *(MANDATORY)*
Enter the appropriate five character Healthcare Common Procedure Coding System (HCPCS) code for the approved service provided.

HCPCS Code	Description
T2031	Assisted Living

NOTE: Use the same procedure code only once per date of service.

24E. DIAGNOSIS POINTER *(MANDATORY)*
Enter A – L which correlates to the diagnosis code entered in Block 21.

24F. CHARGES *(MANDATORY)*
Enter the provider's usual and customary charge for this service in the unshaded portion. For example, if the usual and customary charge is $50.00 enter 50.00.

24G. DAYS OR UNITS *(MANDATORY)*
Enter the number of days that the service was provided for this recipient during the period covered by the dates in block 24A. The units must equal the date of service span.

24I. ID QUALIFIER *(MANDATORY)*
Enter ZZ.

24J. TAXONOMY AND RENDERING PROVIDER ID # *(OPTIONAL)*

1. Enter 310400000X Enter the ALC NPI number in the unshaded portion of the field or leave blank. This will be the same NPI that is used in 33A.

BLOCK 25 FEDERAL TAX ID NUMBER *(MANDATORY)*

The number assigned to the provider by the federal government for tax reporting purposes; also known as a tax identification number (TIN) or employer identification number (EIN).

BLOCK 28 TOTAL CHARGES *(OPTIONAL)*

Enter the sum of the charges in column 24F [lines 1 – 6]. For example, if the sum of the charges in 24F is $1,500.00 enter 1500 00

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER *(MANDATORY)*

The claim must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without a signature and date completed.

BLOCK 33 PROVIDER NAME, ADDRESS AND ZIP CODE *(MANDATORY)*

Enter the billing provider's name and ALC address as shown on the SD MEDX Enrollment record.

33A. *(MANDATORY)*: Enter the billing NPI number of the Assisted Living Center.

33B. *(MANDATORY)*: Enter ZZ310400000X with no spaces.

HEALTH INSURANCE CLAIM FORM APPROVED BY

NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | 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): 111111111

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JANE

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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

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*, 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 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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F70 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	10 01 17 | 10 06 17	13		T2031		A	300 00	6		ZZ NPI	310400000X 1111111111
2	10 07 17 | 10 11 17	12		T2031		A	250 00	5		ZZ NPI	310400000X 1111111111
3	10 12 17 | 10 22 17	13		T2031		A	550 00	11		ZZ NPI	310400000X 1111111111
4	10 23 17 | 10 25 17	21		T2031		A	150 00	3		ZZ NPI	310400000X 1111111111
5	10 26 17 | 10 31 17	13		T2031		A	300 00	6		ZZ NPI	310400000X 1111111111
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111111111 X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1500 00

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.)

John Doe *11-01-17*

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NUCC b.

33. BILLING PROVIDER INFO & PH # ( )

WAIVER PLACE
123 HAPPY STREET
PIERRE, SD 57501

a. 1111111111 b. ZZ 310400000X

Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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