CMS-1450 Instructions

The following table identifies the fields that are required and provides a description of the field.

FORM FIELD	REQUIRED	DESCRIPTION
Form Locator 01 - Provider Name, Address, and Telephone Number	YES	Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.
Form Locator 02 - ERO Assigned Number		
Form Locator 03 - Patient Control No.		
Form Locator 04 - Type of Bill	YES	
Form Locator 05 - Fed. Tax No.	YES	Enter Tax ID Information
Form Locator 06 - Statement Covers Period (From - Through)	YES	Enter the first date of service (DOS) in the "from" column and the last DOS in the "through" column. The dates may not span more than one calendar month. Enter both dates in MM/DD/YY Format (e.g., January 2, 2004, would be 010204).
Form Locator 07 - Cov D.	YES	Enter the total number of days covered by the primary payer, as qualified by the payer organization.
Form Locator 08 - N-C D.		
Form Locator 09 - C-I D.		
Form Locator 10 - L-R D.)		
Form Locator 11 - Unlabeled Field		
Form Locator 12 - Patient Name	YES	Enter the recipient's last name, first name, and middle initial.
Form Locator 13 - Patient Address	YES	Enter the detention facility's address where the recipient resides. If recipient in custody of Border Patrol, enter the Border Patrol Station of the Border Patrol Officers. Do not use the detainee's home address.
Form Locator 14 - Birthdate	YES	
Form Locator 15 - Sex	YES	
Form Locator 16 - Marital Status		
Form Locator 17 - Admission Date	YES	
Form Locator 18 - Admission Hr		
Form Locator 19 - Admission Type	YES	
Form Locator 20 - Admission Src	YES	
Form Locator 21 - D Hr		
Form Locator 22 - Stat	YES	
Form Locator 23 - Medical Record No.		
Form Locator 24-30 - Condition Codes	YES	
Form Locator 31 - Unlabeled Field		
Form Locator 32-35 a-b - Occurrence Code and Date		
Form Locator 36 a-b - Occurrence Span Code (From - Through)		
Form Locator 37 A-C - Internal Control Number/Document Control Number		
Form Locator 38 - Responsible Party Name and Address	YES	Enter: VA Financial Services Center, PO Box 149345, Austin, TX 78714-9435, 1-800-478-0523

Form Locator 39-41 a-d - Value Code and Amount	YES	
Form Locator 42 - Rev. Cd.	YES	Enter the appropriate national four-digit revenue code. Enter the DOS in MM/DD/YY Format in Form Locator 43 or Form Locator 45. When series billing (i.e., billing from two to four DOS on the same line), indicate the DOS in the following Format: MM/DD/YY MM/DD MM/DD MM/DD. Indicate the dates in ascending order. Providers may enter up to four DOS for each revenue code if: All DOS are in the same calendar month. All procedures performed are identical. All procedures were performed by the same provider. If it is necessary to indicate more than four DOS per revenue code, indicate the dates on the subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim including the "Total Charges" line.
Form Locator 43 - Description	YES	Enter the appropriate description for the national four-digit revenue code
Form Locator 44 - HCPCS/Rates	YES	Enter the single most appropriate procedure code for every revenue code on every outpatient claim
Form Locator 45 - Serv. Date	YES	Enter the DOS in MM/DD/YY Format in Form Locator 45.
Form Locator 46 - Serv. Units	YES	Enter the number of covered visits, when appropriate.
Form Locator 47 - Total Charges	YES	Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, "statement covers period."
Form Locator 48 - Non-covered Charges		
Form Locator 49 - Unlabeled Field		
Form Locator 50 A-C - Payer	YES	Immigration Health Services
Form Locator 51 A-C - Provider No.		
Form Locator 52 A-C - Rel Info		
Form Locator 53 A-C - Asg Ben		
Form Locator 54 A-C & P - Prior Payments		
Form Locator 55 A-C & P - Est Amount Due	YES	
Form Locator 56 - Unlabeled Field		
Form Locator 57 - Unlabeled Field		
Form Locator 58 A-C – Insured's Name	YES	
Form Locator 59 A-C - P. Rel		
Form Locator 60 A-C - Cert. - SSN - HIC. - ID No.	YES	All claims require one of the following recipient numbers in order for processing. Enter the recipient's Alien Identification Number. If not available, enter recipient's Fingerprint ID Number. If not available, enter recipient's Event Number. Do not enter any other numbers or letters. It is the referring custodial facility's responsibility to provide this information to the provider.
Form Locator 61 A-C - Group Name		
Form Locator 62 A-C - Insurance Group No.		
Form Locator 63 A-C - Treatment Authorization Codes	YES	Enter the Authorization # for service. All Claims require an Authorization # for processing. It is the referring custodial facility's responsibility to provide this information to the provider.
Form Locator 64 A-C - ESC		
Form Locator 65 A-C - Employer Name		
Form Locator 66 A-C - Employer Location		
Form Locator 67 - Prin. Diag Cd.	YES	Enter the full most current edition International Classification of Diseases, Clinical Modification (up to five digits) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode).

Form Locator 68-75 - Other Diag. Codes	YES WHEN APPLICABLE	
Form Locator 76 - Adm. Diag. Cd.	YES	
Form Locator 77 - E-Code		
Form Locator 78 - Race/Ethnicity		
Form Locator 79 - P.C.		
Form Locator 80 - Principal Procedure Code and Date	YES WHEN INPATIENT ONLY	
Form Locator 81 - Other Procedure Code and Date		
Form Locator 82 a-b - Attending Phys. ID	YES	Enter attending physician’s name.
Form Locator 83 a-b - Other Phys. ID		
Form Locator 84 a-d - Remarks		
Form Locator 85 - Provider Representative	YES	The provider or the authorized representative must sign in Form Locator 85. Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.
Form Locator 86 - Date	YES	Enter the month, day, and year on which the claim is submitted. The date must be entered in MM/DD/YY or MM/DD/YYYY Format.