# CMS-1500 Instructions

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

| FORM FIELD | REQUIRED | DESCRIPTION |
|---|---|---|
| Element 01 - Program Block/Claim Sort Indicator | YES | |
| Element 01a – Insured's I.D. Number | 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. |
| Element 02 – Patient's Name | YES | Enter the recipient's last name, first name, and middle initial. |
| Element 03 – Patient's Birth Date, Patient's Sex | YES | Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box. |
| Element 04 – Insured's Name | YES | |
| Element05 – Patient's 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 Officer(s). Do not use the detainee's home address. |
| Element 06 - Patient Relationship to Insured | | |
| Element 07 – Insured's 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 custodial Border Patrol Officers. |
| Element 08 - Patient Status | | |
| Element 09 - Other Insured's Name | | |
| Element 10 - Is Patient's Condition Related to | YES | |
| Element 11 – Insured's Policy, Group, or FECA Number | YES | |
| Element 11a – Insured's Date of Birth and Sex | YES | |
| Element 11b - Employer's Name or School Name | | |
| Element 11c - Insurance Plan Name or Program Name | YES | Enter "Immigration Health Services" |
| Elements 12 and 13 - Authorized Person's Signature | YES | |
| Element 14 - Date of Current Illness, Injury, or Pregnancy | | |
| Element 15 - If Patient Has Had Same or Similar Illness | | |
| Element 16 - Dates Patient Unable to Work in Current Occupation (not required) | | |
| Elements 17 and 17a - Name and I.D. Number of Referring Physician or Other Source | YES WHEN APPLICABLE | |
| Element 18 - Hospitalization Dates Related to Current Services | YES WHEN APPLICABLE | |
| Element 19 - Reserved for Local Use | | |
| Element 20 - Outside Lab? | | |
| Element 21 - Diagnosis or Nature of Illness or | YES | Enter the most current International Classification of Diseases, |

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| Injury | | Clinical Modification (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. |
| Element 22 - Medicaid Resubmission | | |
| Element 23 - Prior Authorization Number | 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. |
| Element 24A - Date(s) of Service | YES | Enter the month, day, and year for each service using the following guidelines: |
| Element 24A - Date(s) of Service | | When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field. |
| Element 24A - Date(s) of Service | YES | When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field. When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing only the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field. It is allowable to enter up to four DOS per line if: All DOS are in the same calendar month. All services are billed using the same procedure code and modifier(s), if applicable. All services have the same place of service (POS) code. All services were performed by the same provider. The same diagnosis is applicable for each service. The charge for all services is identical. (Enter the total charge per detail line in Element 24F.) The number of services performed on each DOS is identical. All services have the same family planning indicator, if applicable. All services have the same emergency indicator, if applicable. |
| Element 24B - Place of Service | YES | Enter the appropriate two-digit POS code for each service. |
| Element 24C - Type of Service | YES | |
| Element 24D - Procedures, Services, or Supplies | YES | Enter the single most appropriate five-character procedure code. Claims received without an appropriate procedure code may be denied. Modifiers: Enter the appropriate modifier(s) in the "Modifier" column of Element 24D. |
| Element 24E - Diagnosis Code | YES | Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21. |
| Element 24F - $ Charges | YES | Enter the total charge for each line item. |
| Element 24G - Days or Units | YES | Enter the appropriate number of units billed for each line item. Always use a decimal (e.g., 30 minutes equals 2.0 units). |
| Element 24H - EPSDT/Family Plan | YES WHEN APPLICABLE | |
| Element 24I - EMG | | Enter an "E" for each procedure performed as an emergency. If the procedure is not an emergency, leave this Element blank. |
| Element 24J - COB | | |
| Element 24K - Reserved for Local Use | | |
| Element 24K - Reserved for Local Use | | |
| Element 25 - Federal Tax I.D. Number | YES | Enter Tax ID Information |
| Element 26 – Patient's Account No. | | |
| Element 27 - Accept Assignment | | |
| Element 28 - Total Charge | YES | Enter the total charges for the claim. |
| Element 29 - Amount Paid | YES WHEN APPLICABLE | |
| Element 30 - Balance Due | YES | |

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| Element 31 - Signature of Physician or Supplier | YES | The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format. Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date. |
| Element 32 - Name and Address of Facility Where Services Were Rendered | YES | |
| Element 33 – Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone # | YES | Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number. |