gainwell

GreenMountainCare
A HEALTHIER STATE OF LIVING

CMS-1500 and UB-04 Billing Guide

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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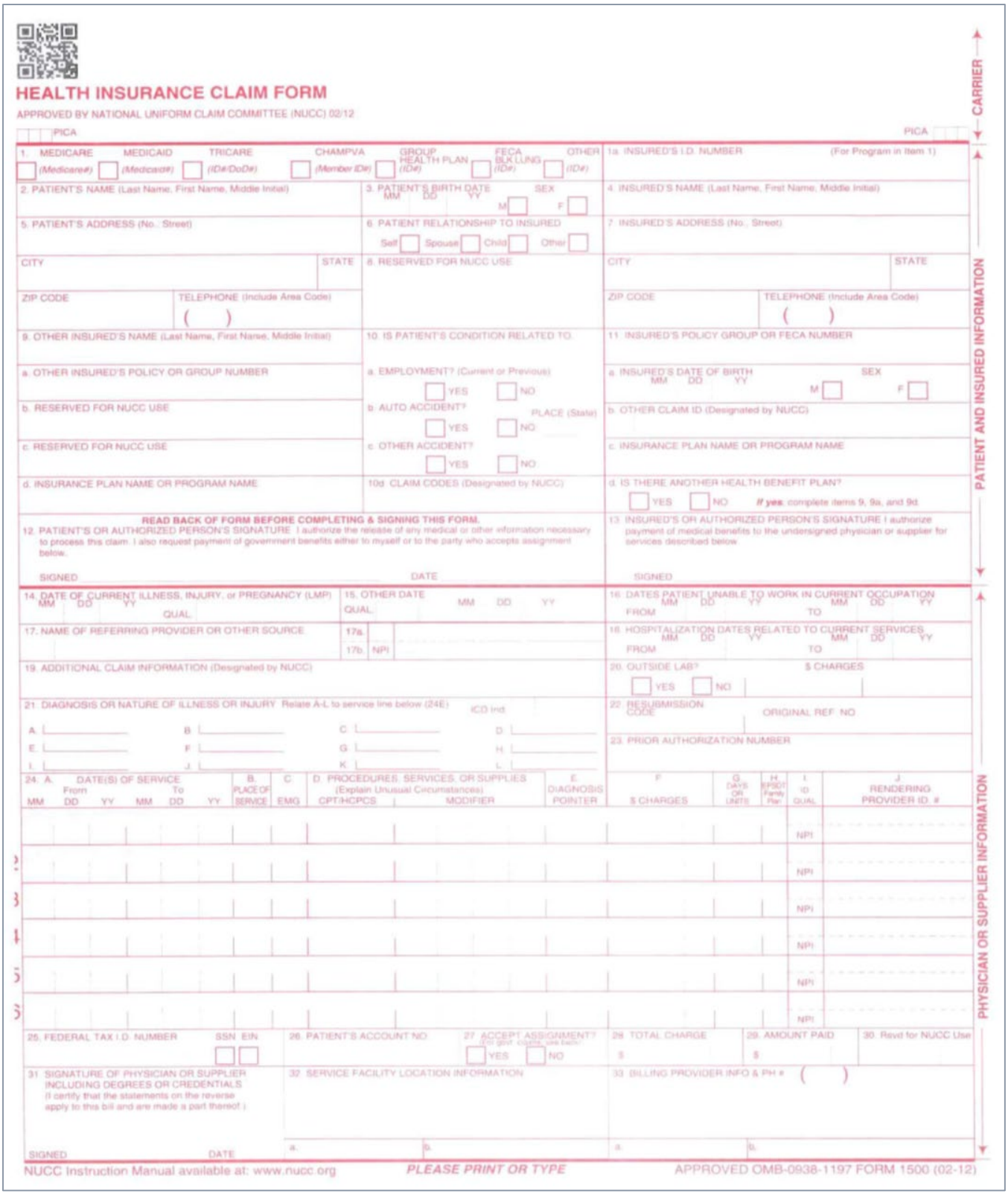
Section 1 CMS-1500 Claim Form



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)

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

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? PLACE (State) YES NO

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. CLAIM CODES (Designated by NUCC)

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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.

A. 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. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Section 2 Paper Claim Billing Instructions/Field Locators

2.1 Field Locators

All information on the CMS-1500 Claim Form should be typed or legibly printed.

Only the 02-12 version of this form is accepted for processing. The field locators listed below are used by Gainwell Technologies when processing Vermont Medicaid claims. The field locators designated by an asterisk (*) are mandatory; other field locators are required when applicable.

The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

Field Locator		Required Information
1.	Carrier Identification	Check the Medicaid box
1a.	Insured's ID Number*	Enter the Vermont Medicaid Unique ID as shown on the member's Member ID card.
2.	PATIENT'S NAME*	Enter the member's last and first name.
10.	CONDITION RELATED TO*	Check appropriate box to indicate: a. If condition is related to employment b. If condition is related to an auto accident c. If condition is related to any other type of accident. *If yes is checked in any of these boxes, enter the accident date in field locator 15.*
11.	INSURED'S POLICY NUMBER	If the member has other health insurance (excluding Medicare), enter the applicable policy number. 1. Enter the insured's date of birth in MMDDYY format; check the appropriate box to indicate insured's sex 2. Enter the insured's employer or school name 3. Enter the name of the other health insurance carrier
11b.	OTHER CLAIM ID (DESIGNATED BY NUCCU)	Property casualty payers, e.g. automobile, homeowner's, or worker's compensation insurers and related entities are to use qualifier "Y4" and the Agency (property casualty) claim number as the identifier. Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For workers compensation and property casualty enter the claim number assigned by the payer (if known).
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN*	Check the appropriate box. *If yes, complete fields 9 a-c.* Health benefits provided under Green Mountain Care are not considered other insurance. Other insurance only pertains to a private health insurance carrier.
14.	DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY	Enter the first date of present illness injury, or pregnancy. For pregnancy, use the date of last menstrual period. Use qualifier "431" - Onset of Current Symptoms or Illness or "484" – Last Menstrual Period (LMP)

15.	OTHER DATE (ACCIDENT DATE)	If your response indicates a 'yes' in field locators 10b or 10c, enter the date of the occurrence and qualifier "439".
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name (First, Middle Initial, Last) followed by the credentials of the professional who referred/ordered the service or supply. If multiple providers apply, enter one provider/qualifier in the following order: 1. DN – Referring Provider 2. DK – Ordering Provider 3. DQ – Supervising provider *Exception: Professional/Professional Crossover Claims require the Ordering qualifier "DK" to be used first when the provider in Field 17 is an Independent Lab, Independent Radiology, DME Supplier, Prosthetics/Orthotics or Sole source Eye Glass provider.*
17a.	ID NUMBER OF REFERRING PROVIDER OR OTHER SOURCE	Enter the other ID number of the referring, ordering, or supervising provider. Use the appropriate qualifier to indicate what the ID number represents; enter in field immediately to the right of 17b. Refer to http://nucc.org/ for list of valid qualifiers. Entry must support information entered in field 17. If applicable, field is required.
17b.	NPI*	Enter the referring, ordering or supervising provider's NPI. Entry must support information entered in field 17. If applicable, field is required.
19.	LOCAL USE	Use this field to explain unusual services or circumstances and to indicate "page x of y" of a multiple page claim.
21.	ICD Ind.*	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. • 9 = ICD-9-CM • 0 = ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.
21.	DIAGNOSIS CODE(S)*	Enter the appropriate diagnosis code(s) that relates to the service rendered. You may use up to twelve diagnosis codes.
24a.	DATE(S) OF SERVICE*	Enter the date of each service provided. If the "From" and "To" dates are the same, the "To" date is not required.
24b.	PLACE OF SERVICE*	Enter the appropriate two-digit place of service code.
24c.	EMG	Enter '1' to indicate if the service provided was the result of an emergency. **This field is mandatory ONLY if emergency services were provided.*
24d.	PROCEDURE CODE*	Enter the appropriate procedure code to explain the service rendered.

24e.	DIAGNOSIS POINTER*	Enter the appropriate diagnosis 'pointer' that relates to the service rendered from field locator 21. *NOTE: The pointer character has changed from numbers to letters.*
24f.	CHARGES*	Enter the usual and customary charge for the service rendered.
24g.	DAYS OR UNITS*	Enter the number of days or units of service which were rendered.
24h.	EPSDT/FAMILY PLAN	Enter one of the following Vermont Medicaid EPSDT and Family Planning indicators: • 1 = Both EPSDT and Family Planning • 2 = Neither EPSDT nor Family Planning • 3 = EPSDT Only • 4 = Family Planning Only
24j.	ATTENDING PROVIDER*	Enter attending physician's NPI. Enter the billing provider NPI for independent labs and DME suppliers. If Atypical, enter the 7-digit Vermont Medicaid provider ID number in the shaded area.
26.	PATIENT'S ACCOUNT NUMBER	Enter the account number you have assigned to the member. Gainwell Technologies can accept up to 12 digits; alpha, numeric, or alpha/numeric in this field. This information will print on the Remittance Advice summary for your accounting purposes.
28.	TOTAL CHARGE*	Add the charges from field locator 24f for each line and enter the total in this field.
29.	AMOUNT PAID*	Enter the amount paid by other health insurance coverage (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is $3.00 or less.
31.	SIGNATURE	Enter the provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature.
33.	BILLING PROVIDER*	Enter the payee provider name and address (Individual provider format: last name, first name)
33a.	BILLING PROVIDER'S NPI*	Enter the billing provider's NPI.
33b.	BILLING PROVIDER'S TAXONOMY	Enter the billing provider's taxonomy code when applicable. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.

9.	OTHER INSURED'S NAME	Enter the other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the policy or group number of the other insured. The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9.
9b.	Reserved for NUCC Use	
9c.	Reserved for NUCC Use	

Section 3 Field Locators Detail

All information on the CMS 1500 Claim Form should be typed or legibly printed. Only the 02-12 version of this form is accepted for processing. The field locators listed below are used by Gainwell when processing Vermont Medicaid claims. The field locators designated by an asterisk (*) are mandatory; other field locators are required when applicable. The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

3.1 Field 1a: Insured's ID Number

Field 1a Other Claim ID (Designated by NUCCU) – Enter the Vermont Medicaid Unique ID as shown on the beneficiary's Member ID card.

3.2 Field 2: Patient's Name

Field 2 Patient's Name – Enter the beneficiary's last and first name.

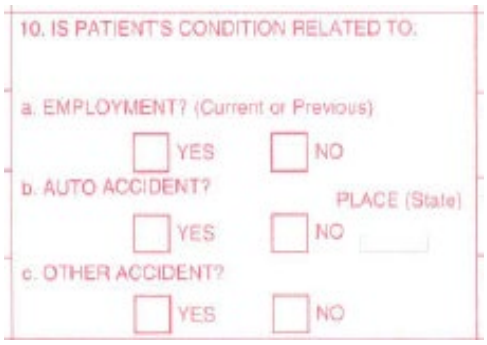
3.3 Field 10: Patient's Condition Related To

Check appropriate box to indicate:

a. Condition is related to employment

b. Condition is related to auto accident

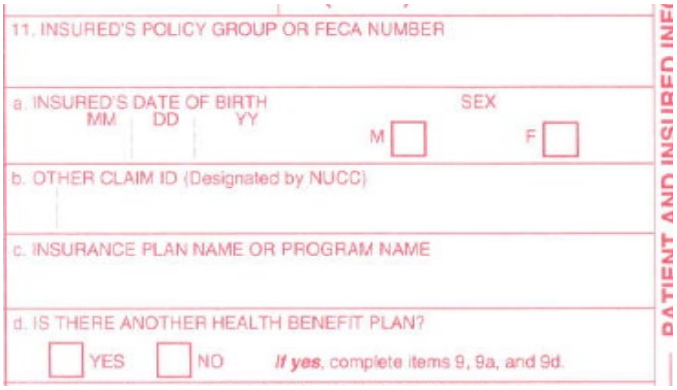
c. Condition is related to any other type of accident



3.4 Field 11b: Other Claim ID

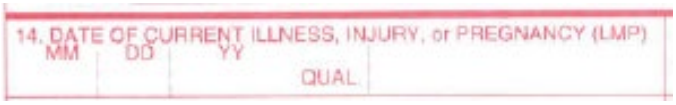
Field 11b Other Claim ID (Designated by NUCCU) – Enter the "Other Claim ID".

When submitting to property and casualty payers, e.g., automobile, homeowner's, or worker's compensation insurers and related entities, use qualifier -Y4 and identifier - Agency Claim Number (Property Casualty Claim Number). Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For worker's compensation or property casualty: If known, enter the claim number assigned by the paper.



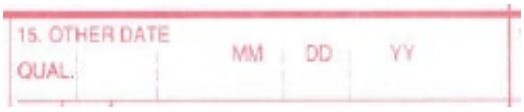
3.5 Field 14: Date of Current Illness, Injury, or Pregnancy (LMP)

Field 14. Date of Current Illness, Injury or Pregnancy - Enter the date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of last menstrual period (LMP). Enter the applicable qualifier:
431 - Onset of Current Symptom or Illness or
484 - Last Menstrual Period.



3.6 Field 15: Other Date

Providers are instructed to put a valid date and valid qualifier in this field. If an Accident Date needs to be reported, the date is to be entered in this field using qualifier "439".



3.7 Field 17: Name of Referring Provider or Other Source

Enter the name (First, Middle Initial, Last) followed by the credentials of the provider who referred/ordered the service or supply. If multiple providers are involved, enter one provider and the applicable qualifier in the following order:

1) DN - Referring Provider

2) DK - Ordering Provider

3) DQ - Supervising Provider

Exception: All professional and professional crossover claims require the Ordering Qualifier - DK to be listed 1st when the Provider in Field 17 is one of the following provider types: Independent Laboratory, Independent Radiology, DME Supplier, Prosthetics/Orthotics, Sole-source eye glass provider.

3.8 Field 17a & 17b NPI

Information must support the qualifier information indicated in Field 17. Enter the other ID number of the referring, ordering, or supervising provider. Use the appropriate qualifier to indicate what the ID number represents; enter in field to the immediate right of 17a. Refer to http://nucc.org/ for list of valid qualifiers.

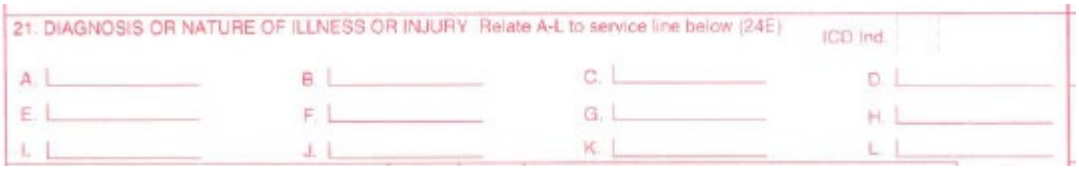
3.9 Field 21: Place of Treatment

Field 21. (ICD Ind.)

An ICD indicator has been added to this field; enter a "9" to indicate that you are using ICD-9 or "0" for ICD-10. Effective 10/1/15, ICD-10 diagnosis codes must be used. This information is required.

Field 21. Diagnosis codes A-L

Enter the appropriate ICD-9 or ICD-10 diagnosis code that relates to the service rendered. You are now able to enter up to 12 diagnosis codes in this field.



3.10 Field 24

24a. DATE(S) OF SERVICE*

Enter the date of each service provided. If the From and To dates are the same, the To date is not required.

24b. PLACE OF SERVICE*

Enter the appropriate two-digit place of service code.

24d. PROCEDURE CODE*

Enter the appropriate procedure code to explain the service rendered.

24e. DIAGNOSIS POINTER*

Enter the appropriate diagnosis 'pointer' that relates to the service rendered (A through L) and corresponds to the diagnosis from field locator 21. You may enter up to 4 pointers per detail.

24f. CHARGES*

Enter the usual and customary charge for the service rendered.

24g. DAYS OR UNITS*

Enter the number of days or units of service rendered.

24j. ATTENDING PROVIDER*

Enter attending physician's NPI. Enter the billing provider NPI for independent labs and DME suppliers. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.

3.11 Field 28 Through 33a

28. Total Charge*

Add the charges from field locator 24f for each line and enter the total in this field.

29. Amount Paid*

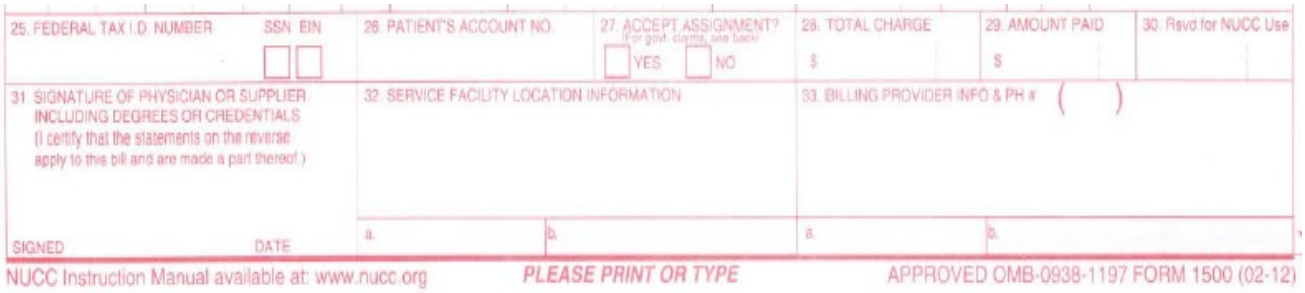
Enter the amount paid by other health insurance coverage (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is $3.00 or less.

33. Billing Provider*

Enter the payee provider name and address (Individual provider format: last name, first name)

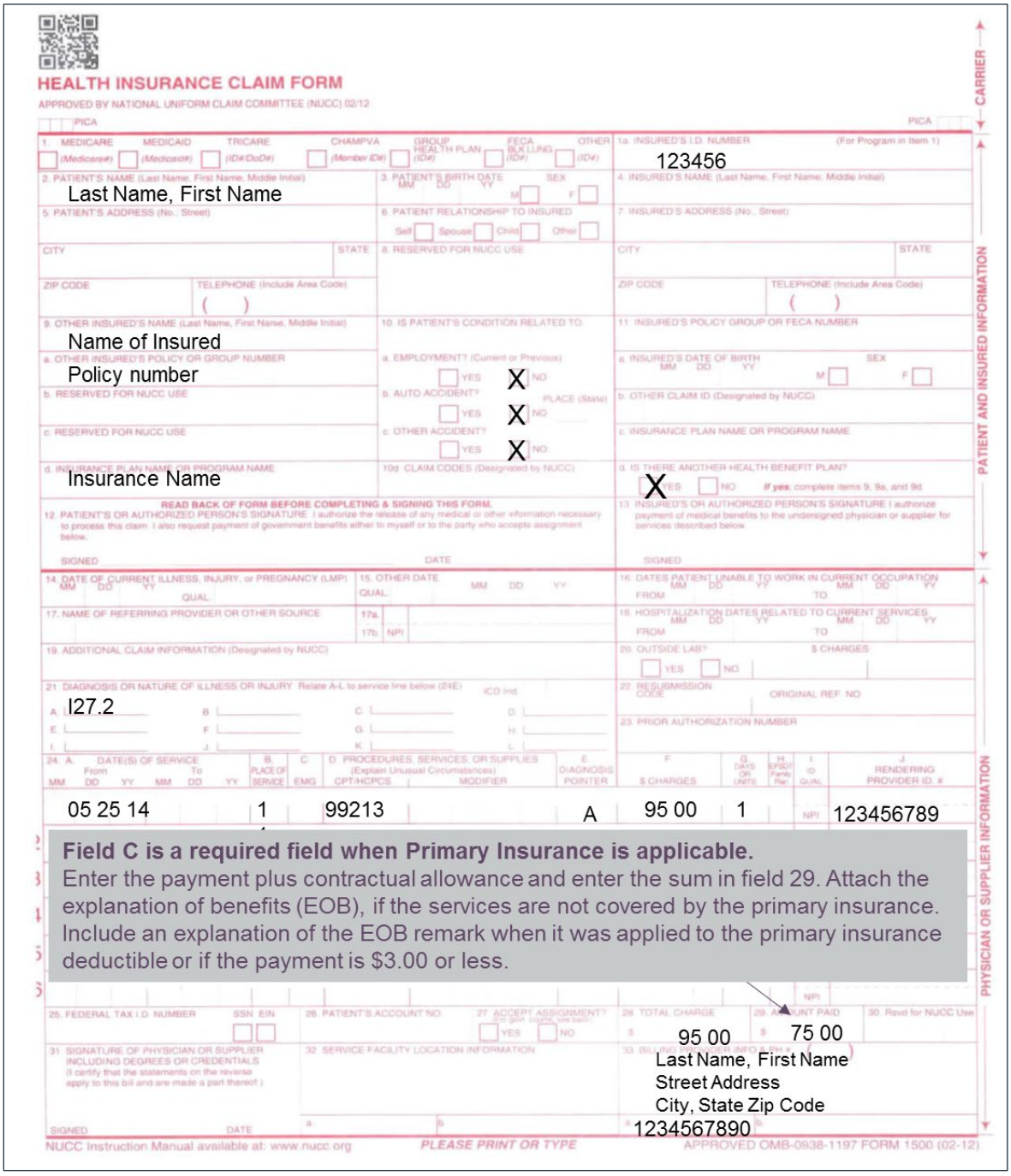
33a. Billing Provider's NPI*

Enter the billing provider's NPI.



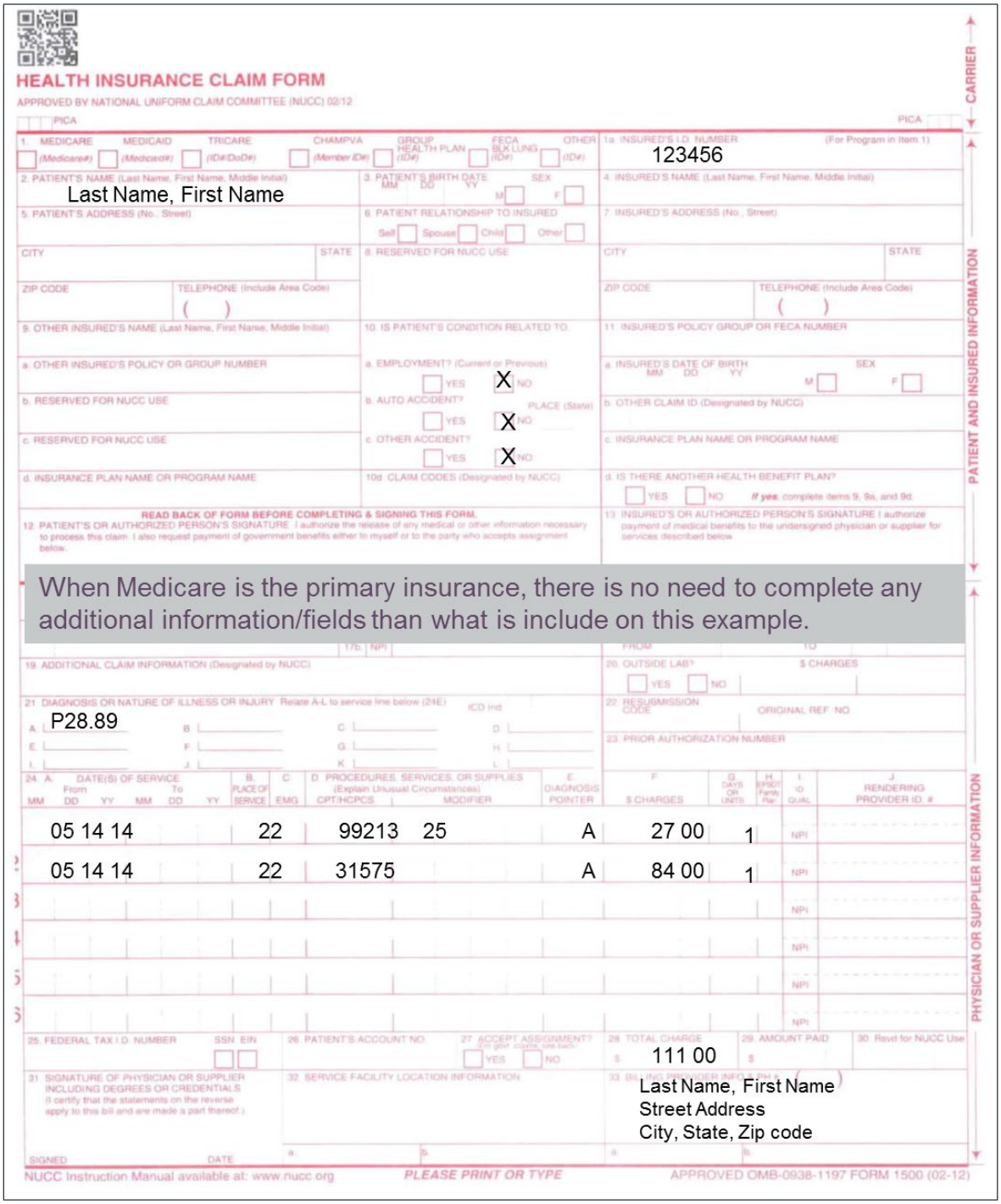
Section 4 Primary Insurance Claim Example

Enter the amount paid by other health insurance coverage, including contractual allowance if applicable (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down, if applicable. Documentation must be attached if the services are not covered by the primary insurer, or if the payment by the primary is $3.00 or less.



Section 5 Medicare Claim Example

If you do not receive payment from DVHA within 30 days of the Medicare paid date, submit the claim to Gainwell with a completed *Medicare Attachment Summary Form.* If a service or item is denied by Medicare as non-reimbursable but the service is reimbursable by Vermont Medicaid, submit a CMS 1500 claim for the non-reimbursable service (completed to DVHA specifications) include a copy of the Medicare denial within twelve months of the date of service to Gainwell.



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): 123456

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

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 X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

When Medicare is the primary insurance, there is no need to complete any additional information/fields than what is include on this example.

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)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A P28.89 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. #
05 14 14		22		99213	25	A	27 00	1		NPI	
05 14 14		22		31575		A	84 00	1		NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 111 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( )

Last Name, First Name
Street Address
City, State, Zip code

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Section 6 Multiple Page Claims

When billing a multiple page claim, you must indicate "page x of y" in Box 19, "Local Use" of the CMS-1500 claim form. To indicate the conclusion of the entire claim, field 28 of the last page of the claim must also include the total billed amount. Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) & 3 of 3 (3rd page of claim).

Section 7 Common Mistakes

- Alignment – text entered on the claim is offset from the boxes on the claim form
- Mandatory Fields are not completed
- Individual Provider Name (Field Locator 33) is incorrectly formatted. This should be Last Name, First Name to be considered correctly formatted
- Insured's ID should not be the social security number, it should be the beneficiary's Vermont Medicaid Unique ID (UID) Number

Section 8 Frequently Asked Questions

Q. What is a diagnosis pointer?
A. The diagnosis pointer(s) go in field 24E and they relate back to the diagnoses indicated in field 21.

Q. Does the provider have to sign the claim form?
A. The provider does not have to sign the claim form.

Q. What is a taxonomy code?
A. The taxonomy indicates the specialty of the provider. You would have indicated this when you applied for your NPI.

Q. Where do we get the diagnosis codes?
A. You get the diagnosis codes from the ICD-10 for Diagnosis Codes manual or go www.ICD10data.com

Q. What is a CPT code or HCPCS?
A. The CPT code or HCPCS is the code that describes the service you have rendered. You must use a CPT manual to research what codes to bill.

Q. Why are claims returned that have staples?
A. Staples cause issues with our optical character reader. Even if they are removed, the holes they create can cause the optical scanner to jam.

Q. Where do we find CMS 1500 claim forms?
A. You can get CMS 1500 claims forms at an office supply store.

Section 9 UB-04 Paper Claim Billing Instructions/Field Locators

9.1 Field Locators

All information on the UB-04 Claim Form should be typed or legibly printed. The field locators listed below are used by Gainwell Technologies when processing Vermont Medicaid claims. The field locators designated by an asterisk (*) are mandatory; other field locators are required when applicable.

The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

FIELD LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter pay to name and pay to address.
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill.
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth.
11. PATIENT SEX	Enter the patient's gender.
12. ADMISSION DATE*	Enter date of admission.
13. ADMISSION HOUR	Enter the hour in which patient was admitted.
14. ADMISSION TYPE	Enter the code indicating the priority of the admission: • 1 - Emergency

	• 2 - Urgent • 3 - Elective • 4 - Nursery
17. STAT*	Enter the two-digit code indicating the patient's status as of the statement period. For SIA Payment, please indicate date of death.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): • 02 - Condition is Employment Related • A1 - EPSDT Related Services • A4 - Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two-digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: • 01 - Auto Accident • 02 - Auto Accident/No Fault Insurance Involved • 03 - Accident/Tort Liability • 04 - Accident/Employment Related • 05 - Other Accident • 06 - Crime Victim • 11 - No Accident/Onset of Symptoms or Illness • 35 - Physical Therapy • 42 - Date of Discharge • 44 - Occupational Therapy • 45 - Speech Therapy • 50 - Medical Emergency-Non-accidental • 51 - Outpatient Surgery Related • 52 - Not an Accident
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided. Each date of service must be entered separately at the detail.

45. SERVICE DATE*	Enter the actual date the service was rendered. Enter the from date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of visits or units of time for which reimbursement is being requested.
47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	Enter “Medicare” or “Spend Down” (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter “Vermont Medicaid” on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider’s NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider’s Taxonomy Code.
57c. VERMONT MEDICAID ID #	Atypical providers enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-10-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-10-CM codes for any condition other than primary, which requires supplementary treatment.

74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-10-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-10-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.