



CMS 1500 and UB 04 Billing Guide



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Section 1 CMS 1500 Claim Form Example

HEALTH INSURANCE CLAIM FORM PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12					
PICA					PICA
1. MEDICARE MEDICAID TRICARE CHAMPV (Medicare#) (Medicaid#) (ID#/DoD#) (Member li	- HEALTH PLAN	FECA OTHER BLK LUNG (ID#)	1a. INSURED'S I.D. NUMBE	R (F	For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH D		4. INSURED'S NAME (Last I	Name, First Name, Midd	de Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATION	MF	7. INSURED'S ADDRESS (N	In Street)	
	Self Spouse	Child Other	(
CITY STATE	8. RESERVED FOR NU	ICC USE	CITY		STATE
ZIP CODE TELEPHONE (Include Area Code)	_		ZIP CODE	TELEPHONE (In	idude Area Code)
()				()	0119398
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CON	DITION RELATED TO:	11. INSURED'S POLICY GR	OUP OR FECA NUMBI	≅R.
a, OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Cu		a. INSURED'S DATE OF BIR	RTH YY	SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	NO PLACE (State)	b. OTHER CLAIM ID (Desig	М	F
	YES	NO L		WALLIANCOROLOG - 22% VEVALK OVERS	
c. RESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	Пио	c. INSURANCE PLAN NAME	E OR PROGRAM NAME	
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (De	0.000	d. IS THERE ANOTHER HE.	ALTH BENEFIT PLAN?	(
READ BACK OF FORM BEFORE COMPLETING	A SIGNATURE FORM		YES NO <i>If yes</i> , complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize		
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the to process this claim. I also request payment of government benefits either 	release of any medical or c	other information necessary	payment of medical bene services described below	fits to the undersigned	physician or supplier for
below.			Warner St. Characteristic Landaugh Consolidation (1992), Antachta		
SIGNED	DATE OTHER DATE	S CORTAGO SACOLAS	SIGNED 16. DATES PATIENT UNABI MM DD	LE TO WORK IN CURP	RENT OCCUPATION
QUAL.	. MIM	DD YY	FROM	ТО	
17, NAME OF REFERRING PROVIDER OR OTHER SOURCE 178			18. HOSPITALIZATION DAT MM DD DD FROM DD	ES RELATED TO CUF YY M TO	M DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB?	\$ CHAF	IGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	ice line below (24E)	CD Ind.	YES NO 22. RESUBMISSION CODE		
A.L B.L C.L		D. L	(FLT-SHEET	ORIGINAL REF.	NO.
E.L		н [23. PRIOR AUTHORIZATIO	NUMBER	
	DURES, SERVICES, OR in Unusual Circumstance		F. G	i. H. I. YS EPSOT ID.	J. RENDERING
MM DD YY MM DD YY SERVICE EMG CPT/HCF			\$ CHARGES UN	R Family ID. ITS Plan QUAL	PROVIDER ID. #
				NPI	
	1 1 1	1 1	1 1	1 1	
				NPI	
				NPI	
				NPI NPI	
	1 1 1		r i i	<u> </u>	
				NPI	
				NPI NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	ACCOUNT NO. 27.	(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 32. SERVICE FA	CILITY LOCATION INFO	III III	33. BILLING PROVIDER INF	T.)
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)					
a. NI	D. b.		a. NPI	b.	

Section 2 Paper Claim Billing Instructions/Field Locators

All information on the CMS 1500 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 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: If condition is related to employment If condition is related to an auto accident 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. Enter the insured's date of birth in MMDDYY format; check the appropriate box to indicate insured's sex Enter the insured's employer or school name 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.

Field Locator	Required Information
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: • DN – Referring Provider • DK – Ordering Provider • 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 https://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 ICD indicator; 0 = ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.

Field Locator	Required Information
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.

Field Locator	Required Information
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.	Enter the billing provider's taxonomy code when applicable.
BILLING PROVIDER'S TAXONOMY	If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.
	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.
9. OTHER INSURED'S NAME	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	Enter the policy or group number of the other insured. The "Other Insured's Policy or Group Number" identifies
GROUP NUMBER	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. 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*

Enter the Vermont Medicaid Unique ID as shown on the Member ID card. (Designated by NUCCU)

1a. INSURED'S I.D. NUMBER	(For Program in Item 1)

3.2 Field 2: Patient's Name*

Enter the Member's last and first name.

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

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

10. IS PATIENT'S CONDI	TION RELATED TO:
a. EMPLOYMENT? (Curre	ent or Previous)
YES	NO
b. AUTO ACCIDENT?	PLACE (State)
YES	NO L
c. OTHER ACCIDENT?	
YES	NO

3.4 Field 11b: Other Claim ID

Enter the "Other Claim ID" (Designated by NUCCU). 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)

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
- 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.

```
17, NAME OF REFERRING PROVIDER OR OTHER SOURCE
```

3.8 Field 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 https://nucc.org/ for a list of valid qualifiers.



3.9 Field 21: ICD Ind & Diagnosis Code(s)*

Field 21. (ICD Ind.)

Enter "0" for ICD-10.

Field 21. (Diagnosis codes A-L)

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

21. DIAGNOSIS OR NATURE OF	FILLNESS OR INJURY Relate A-L	to service line below (24E)	ICD Ind.
A. L.	в	c. L	D. L
E	F	G. L	н
1. 1	J	к. 🗀	La L

3.10 Field 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.

3.11 Field 24b. Place of Service*

Enter the appropriate two-digit place of service code.

3.12 Field 24d. Procedure Code*

Enter the appropriate procedure code to explain the service rendered.

3.13 Field 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.

3.14 Field 24f. Charges*

Enter the usual and customary charge for the service rendered.

3.15 Field 24g. Days or Units*

Enter the number of days or units of service rendered.

3.16 Field 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.

	24. A. MM	DAT From DD	TE(S) O	F SERV	To DD	B. PLACE OF SERVICE	C. EMG	D. PROCEDURE: (Explain Unu: CPT/HCPCS	3, SERVI sual Circo L	umstand	R SUPF (es) (IFIER	LIES	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1																	NPI	
2																Ĺ	NPI	
3																	NPI	
4																	NPI	
5											ļ						NPI	
6																	NPI	

3.17 Field 28: Total Charge*

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



3.18 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.



3.19 Field 33: Billing Provider*

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

3.20 Field 33a: Billing Provider's NPI*

Enter the billing provider's NPI.



Section 4 Primary Insurance Claim Example

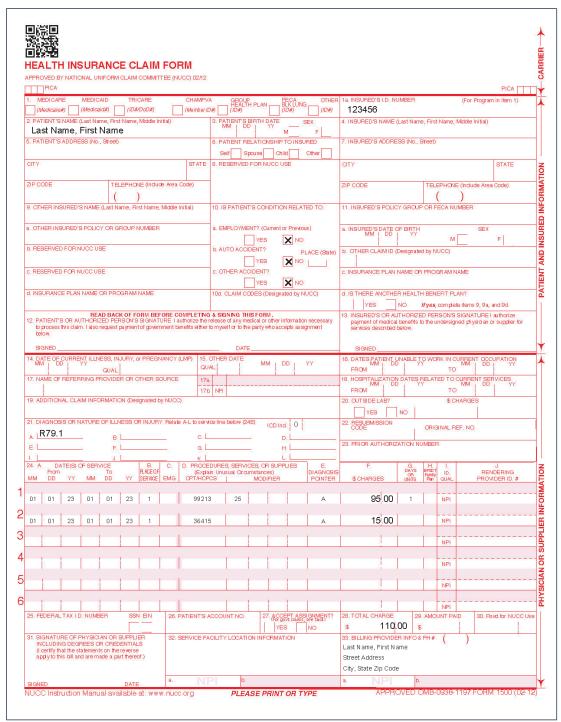
Field C is a required field when Primary Insurance is applicable.

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.

EALTH INSURANCE CLAIM FORM			
PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12			DIO.
MEDICARE MEDICAID TRICARE CHAMPVA	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID	HEALTH PLAN BLK LUNG I	123456	(a riogiani nain i)
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First	Name, Middle Initial)
Last Name, First Name PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
	Self Spouse Child Other		
TTY STATE	8. RESERVED FOR NUCC USE	CITY	STATE
IP CODE TELEPHONE (Include Area Code)		70,0005	DUCKE (Andreas Area Control
()		ZIP CODE TELE	PHONE (Include Area Code)
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FE	CA NUMBER
Name of Insured			
OTHER INSURED'S POLICY OR GROUP NUMBER Policy #	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH	SEX F
RESERVED FOR NUCCUSE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NU	
	YES NO L		age of the second
RESERVED FOR NUCCUSE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROG	RAM NAME
INSURANCE PLAN NAME OR PROGRAM NAME	YES X NO 10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENE	FIT PLAN?
Insurance Name	Total Service Control of the Control		complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the re	& SIGNING THIS FORM.	 INSURED'S OR AUTHORIZED PER payment of medical benefits to the ur 	
to process this claim. I also request payment of government benefits either to below.	to myself or to the party who accepts assignment	services described below.	ide signed prysider or supplier to
SIGNED	DATE	SIGNED	
	OTHER DATE MM . DD . VV	16. DATES PATIENT UNABLE TO WOF	K IN CURRENT OCCUPATION
QUAL. QUA	AL	FROM	то
7. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b.		18. HOSPITALIZATION DATES RELATE MM DD YY	MM DD YY
9. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?	\$CHARGES
		YES NO	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service I 110	ce line below (24E) ICD Ind. 0	22. RESUBMISSION ORIG	NAL REF. NO.
ALIIU BL CL	D. L. H. L.	23. PRIOR AUTHORIZATION NUMBER	
J K. L		9 9 9	-
	DURES, SERVICES, OR SUPPLIES E. in Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	F. G. H. DAYS EFSOT OR Family SCHARGES UNITS Man	I. J. ID. RENDERING QUAL PROVIDER ID. #
01 01 23 01 01 23 1 99213	з А	95 00 1	NPI 1234567890
			NPI
			NPI
			NPI
			NPI
			NPI
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	CCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govit claims, see bads) YES NO	28. TOTAL CHARGE 29. AMOU \$ 95.00 \$	75.00 30. Rsvd.for NUCC U
SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACE	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH#	()
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		Last Name, First Name	7
apply to this bill and are made a part thereof.)		Street Address City, State Zip Code	
		a. 1234567890 b.	

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.



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).

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	

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 <u>not</u> be the social security number, it should be the member'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 to https://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

FIELD LOCATORS	REQUIRED INFORMATION
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.

FIELD LOCATORS	REQUIRED INFORMATION
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.