CMS-1500 Completion Guide
(Oral & Maxillofacial Surgeons)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) — 1

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F — 4

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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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 — 9a

a. EMPLOYMENT? (Current or Previous) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

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**, return to and complete item 9 a-d.*

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

PATIENT AND INSURED INFORMATION

#	FIELD NAME	FIELD INSTRUCTIONS
1	Medicare, Medicaid, Tricare Champus, Champ VA, Group Health Plan, Feca BLK Lung, Other	**OPTIONAL.** Check Medicaid.
1a	Insured's ID Number	**REQUIRED.** Enter the beneficiary's ten-digit Medicaid ID number exactly as it appears on the Medicaid identification card.
4	Insured's Name	**OPTIONAL.** Enter the insured's name (Last Name, First Name, Middle Initial).
9a	Other Insured's Policy or Group Number	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** If you have billed a private insurance or Medicare, then enter the policy number of the insured in this box. Do not use a hyphen or space as a separation within the policy number. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

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1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME 9c

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 9d

10d. RESERVED FOR LOCAL USE 10d

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

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 ______

PATIENT AND INSURED INFORMATION

#	FIELD NAME	FIELD INSTRUCTIONS
9c	Employer's Name or School Name	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** Enter the amount paid by the private insurance or Medicare policy. If the private insurance or Medicare denies payment, put $0.00 in this box and a "1" in Box 10d. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***
9d	Insurance Plan Name or Program Name	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** Enter the carrier code number for the private insurance policy or Medicare in this box. Carrier codes are located in your Medicaid Dental Provider Manual or you can visit the DHHS website at www.scdhhs.gov for the most recent carrier code listing. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***
10d	Reserved for Local Use	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** Enter "1" for a private insurance or Medicare denial or "6" if this person is a crime victim. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

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CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) 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. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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 (11)

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME (11b)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME (11c)

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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. (12)

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

PATIENT AND INSURED INFORMATION

#	Field Name	Field Instructions
11	Insured's Policy Group or FECA Number	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** Report the private insurance or Medicare policy number in this box. Do not use a hyphen or space as a separation within the policy number. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***
11b	Employer's Name or School Name	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** Enter the amount the private insurance company or Medicare has paid to you. If the primary insurance company denies payment, put 0.00 in this box and a "1" in Box 10d. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***
11c	Insurance Plan Name or Program Name	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** Enter the carrier code number of the private insurance or Medicare in this box. Carrier codes are located in your Medicaid Dental Provider Manual or you can visit the DHHS website at www.scdhhs.gov for the most recent carrier code listing. ***Leave this box blank if not reporting a private insurance or a Medicare payment or denial.***
12	Patient's or Authorized Person's Signature	**REQUIRED.** Enter "Signature on file", "SOF" or patient's legal signature. The patient's or authorized person's signature indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

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14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___ 3. ___ . ___
2. ___ . ___ 4. ___ . ___
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

21 24a 24b

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								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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. 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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

#	Field Name	Field Instructions	
21	Diagnosis or Nature of Illness or Injury	**OPTIONAL.** This box is not required, but you may enter a diagnosis code and your claim will not reject. Enter the diagnosis of the patient indicated by the current edition of the International Classification of Diseases, Ninth Edition, Clinic Modification (ICD-9-CM) code number.	
24a	Date(s) of Service	Unshaded	**REQUIRED.** Enter the month, day and year for each procedure. Information has to appear in the "To" section.
24b	Place of Service	Unshaded	**REQUIRED.** Enter the appropriate two-digit place of service code. 11- Office, 12- Home, 21-Inpatient Hospital, 22- Outpatient Hospital, 23 – Emergency Room – Hospital, 24- Ambulatory Surgical Center, 31 – Skilled Nursing Facility, 32 – Nursing Facility, 33 – Custodial Care Facility, 71 – State or Local Public Health Clinic, 72 – Rural Health Clinic, 99 – Other Unlisted Facility.

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14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___ 3. ___ . ___
2. ___ . ___ 4. ___ . ___
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24c 24i 24f 24d

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								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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. 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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

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#	FIELD NAME		FIELD INSTRUCTIONS
24c	EMG (Emergency)	Unshaded	**REQUIRED.** Entering a "Y", if applicable. Emergency patients are exempt from a co-payment. If not an emergency, leave blank.
24d	Procedures, Services, or Supplies CPT/HCPCS	Unshaded	**REQUIRED.** Enter the appropriate CPT procedure code. Oral surgeons must file *only* CPT procedure codes on the CMS 1500 (08/05) Claim Form. CDT procedure codes must be filed on the ADA Claim Form (this includes procedure code D9999). Filing procedures on the wrong claim form will result in a rejected claim.
24d	Procedures, Services, or Supplies Modifier Section	Unshaded	**OPTIONAL.** Modifiers are not required.
24f	Charges	Unshaded	**REQUIRED.** You must enter your usual and customary charge for each procedure code listed.
24i	Rendering Provider ID Qualifier	Shaded	**REQUIRED.** Enter **"ZZ"** as the ID Qualifier.

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 2. 3. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24j
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 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
PHYSICIAN OR SUPPLIER INFORMATION
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. 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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

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<table>
<tr><th>#</th><th>FIELD NAME</th><th colspan="2">FIELD INSTRUCTIONS</th></tr>
<tr><td rowspan="2">24j</td><td rowspan="2">Rendering Provider ID</td><td>Shaded</td><td>REQUIRED. Enter the 10-character taxonomy code of the individual provider who rendered the service.
See the chart below for dental taxonomy codes that may be used.
<table>
<tr><th>Category/Description Code</th><th>Code</th></tr>
<tr><td>Dentists: A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and practicing within the scope of that license.</td><td>122300000X</td></tr>
<tr><td>Dental Specialty (see following list)</td><td>Various</td></tr>
<tr><td>Prosthodontics</td><td>1223P0700X</td></tr>
<tr><td>Oral & Maxillofacial Pathology</td><td>1223P0106X</td></tr>
<tr><td>Oral & Maxillofacial Radiology</td><td>1223D0008X</td></tr>
<tr><td>Oral & Maxillofacial Surgery</td><td>1223S0112X</td></tr>
</table></td></tr>
<tr><td>Unshaded</td><td>REQUIRED. Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-digit NPI may be entered.</td></tr>
</table>

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___ 3. ___ . ___
2. ___ . ___ 4. ___ . ___
22. MEDICAID 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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6			27	28				NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26 26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

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#	FIELD NAME	FIELD INSTRUCTIONS
26	Patient's Account Number	**OPTIONAL.** Put the beneficiary's chart number or account number in this box. The first nine characters will be keyed. The account number is helpful in tracking the claim if the beneficiary's Medicaid ID number is invalid or incorrect. The patient account number will be listed as the "Own Reference Number" on the remittance advice.
27	Accept Assignment	**OPTIONAL.** Complete this box to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.
28	Total Charge	**REQUIRED.** Enter the total amount from all the charges in Box 24f in this box.

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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. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID 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. #
1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
PHYSICIAN OR SUPPLIER INFORMATION
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. 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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

#	Field Name	Field Instructions
29	Amount Paid	**REQUIRED, if applicable. This box is designated for private insurance or Medicare information.** ***Leave this box blank if you are billing Medicaid as the primary payer.*** Enter the total amount from other insurance sources if you have filed with a private insurance or Medicare as primary payers. If the private insurance or Medicare denies payment, put $0.00. ***Required, if reporting a private insurance or Medicare payment or denial.***
30	Balance Due	**REQUIRED.** Enter the balance due in this box.
31	Signature of Physician or Supplier Including Degrees and Credentials	Not required.

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___ 3. ___ . ___
2. ___ . ___ 4. ___ . ___
22. MEDICAID 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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								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. 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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION — 32 — 32a NPI — 32b b.
33. BILLING PROVIDER INFO & PH # ( ) — a. NPI — b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

#	FIELD NAME	FIELD INSTRUCTIONS	
32	Service Facility Location Information	**IF APPLICABLE,** enter the name, address, and ZIP code + 4 of the *service facility* ***if the services were rendered in a facility other than the patient's home or provider's office.***	
		32a	**IF APPLICABLE,** enter the NPI of the service *facility* ***if the services were rendered in a facility other than the patient's home or provider's office.***
		32b	**IF APPLICABLE,** enter the two byte ID Qualifier **"ZZ"** followed by the taxonomy code of the *service facility* ***if the services were rendered in a facility other than the patient's home or provider's office.*** (No spaces between the ID Qualifier and taxonomy code)

CMS-1500 Completion Guide
(Oral & Maxillofacial Surgeons)

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID 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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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. 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.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( ) 33
a. 33a NPI b. 33b

NUCC Instruction Manual available at: www.nucc.org

<table>
<tr><th>#</th><th>FIELD NAME</th><th colspan="2">FIELD INSTRUCTIONS</th></tr>
<tr><td rowspan="3">33</td><td rowspan="3">Billing Provider Information & Phone Number</td><td colspan="2">REQUIRED. Enter the provider of service/supplier's billing name, address, ZIP code + 4, and telephone number. Do not use commas, periods, or other punctuation in the address. When entering a 9-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in this box. This pay-to provider number is indicated on the Remittance Advice and check.</td></tr>
<tr><td>33a</td><td>Required. Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-digit NPI group/organization must be entered. If not billing as a member of a group, then enter the 10-digit individual NPI.</td></tr>
<tr><td>33b</td><td>Required. Enter the two byte ID Qualifier "ZZ" followed by the taxonomy code (no spaces). Example: ZZ1223S0112X.</td></tr>
</table>