Special Edition

DME Medicare News

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Special Edition

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Revisions Made to HCFA-1500 Form Instructions

Dear Physicians and Suppliers,

While the HCFA-1500 form, itself, has not been changed in any way, the form instructions have been revised. Because of this, it is very important that all physicians and suppliers be aware of the following new dates:

- ❑ **September 1, 1995 - New instructions to providers.**
- ❑ **October 1, 1995 - All carriers must have implemented the new instructions. Providers may** begin submitting claims in accordance with the new HCFA-1500 instructions.
- ❑ **March, 1, 1996 - All providers *must* be submitting claims in accordance with the new HCFA-1500 instructions. Claims submitted after this date, which are not in compliance with these instructions, will be returned.**

This special edition of "DME Medicare News" contains an article on the revisions to the HCFA-1500 instructions. We ask that you carefully review these instructions and pay special attention to the dates of implementation. Please note that the article items printed in bold italic typeface denote the newly revised information.

We have also republished the article referencing flu vaccinations. It contains updated information since its original publication in our June 1995 edition.

The remaining articles highlight other information that is of importance to you.

HCFA-1500 Revised Instructions

HCFA-1500 Revisions

The following is a revision to the HCFA-1500 instructions. The form itself has not been changed in any way. Critical implementation dates associated with these new instructions are:

- ❑ September 1, 1995 - New instructions to providers.
- ❑ October 1, 1995 - All carriers must have implemented the new instructions. Providers **may** begin submitting claims in accordance with the new HCFA-1500 instructions.
- ❑ March, 1, 1996 - All providers ***must*** be submitting claims in accordance with the new HCFA-1500 instructions. Claims submitted after this date, which are not in compliance with these instructions, will be returned.

The purpose of these instructions is twofold. First, they resolve problems that have been identified regarding the completion of the HCFA-1500. **Specifically**, it clarifies what information must be entered in items 9, 11, 19, and several others that have been the object of past confusion. Second, it creates a standard national policy for collecting Medicare information on the HCFA-1500 form. Accordingly, carriers may not alter or change these instructions in any way. HCFA, Central Office (CO) is the sole arbiter of how the HCFA-1500 form should be completed. Any deviations from these instructions must be CO approved.

There are three main sections to the new instructions:

- ❑ Section 1 - Purpose of the HCFA-1500 form and Item by Item instructions.
- ❑ Section 2 - Place of Service Codes and Definitions, contains place of service (POS) codes and POS definitions.
- ❑ Section 3 - Exhibits, includes a total of three exhibits that describe printing specifications and standards for the Health Insurance Claim Form HCFA-1500.

NOTE: Items denoted in italics and bold are the new revisions.

Section 1

Purpose of Health Insurance Claim Form - HCFA-1500

The HCFA-1500 answers the needs of many health insurers. It is the basic form prescribed by HCFA for the Medicare program for claims from physicians and suppliers, except for ambulance services. It has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

Use these instructions for completing this form. The HCFA-1500 has space for physicians and suppliers to provide information on other health insurance. Use this information to determine whether the Medicare patient has other coverage which must be billed prior to Medicare payment, or whether there is a Medigap policy under which payments are made to a participating physician or supplier.

Items 1-13 - Patient and Insured Information

Item 1. Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a. Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.

Item 2. Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.

Item 3. Enter the patient's birth date and sex.

Item 4. If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5. Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6. Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7. Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 & 11 are completed.

Item 8. Check the appropriate box for the patient's marital status and whether employed or a student.

Item 9. Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank.

NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions, and only when the beneficiary wishes to assign his / her benefits under a medigap policy to the participating physician or supplier.

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians / suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his / her benefits under a Medigap policy to a participating physician / supplier is called a mandated Medigap transfer.

Medigap — A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of Title XVIII of the Social Security Act. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his / her own supplemental claim.

Item 9a. Enter the policy and / or group number of the Medigap enrollee preceded by **MEDIGAP**.

Item 9b. Enter the Medigap enrollee's birth date and sex.

Item 9c. Disregard "employer's name or school name" which is printed on the form. Enter the claims processing address for the Medigap insurer. Use an abbreviated street address, two letter State postal code, and zip code copied from the Medigap enrollee's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, Maryland 21204

is shown as "1257 Anywhere St MD 21204."

NOTE: If a carrier assigned unique identifier of a Medigap insurer appears in item 9d, item 9c may be left blank.

Item 9d. Enter the name of the Medigap enrollee's insurance company or the Medigap insurer's unique identifier provided by the local Medicare carrier. If you are a participating physician or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in item 9 and its subdivisions must be complete and correct. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Items 10a. thru 10c. Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d. Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11. **THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.**

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If there has been a change in the insured's insurance status, e.g., retired, enter the word "NONE" and proceed to item 11b.

Insurance Primary to Medicare — Circumstances under which Medicare payment may be secondary to other insurance include:

❑ Group Health Plan Coverage:

- Working Aged;
- Disability - (Large Group Health Plan); and
- End Stage Renal Disease.

❑ No Fault and / or Other Liability:

❑ Work-Related Illness / Injury:

- Workers' Compensation;
- Black Lung; and
- Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

Item 11a. Enter the insured's birth date and sex if different from Item 3.

Item 11b. Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter the retirement date preceded by the word "RETIRED."

Item 11c. Enter the complete insurance plan or program name, e.g., Blue Shield of (State). If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.

Item 11d. Leave blank. Not required by Medicare.

Item 12. The patient or authorized representative must sign and date this item unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with §§3047.1 - 3047.3. If the patient is physically or mentally unable to sign, a representative specified in §3008 may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. ***The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.***

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the physician or supplier, when the physician / supplier accepts assignment on the claim.

Signature by Mark (X) — When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his / her name and address next to the mark.

Item 13. The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in Item 9 and its subdivisions. The patient or his / her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating physician / supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

Items 14-33 - Physician or Supplier Information

Item 14. Enter date of current illness, injury, or pregnancy. For chiropractic services, enter the date of the initiation of the course of treatment and enter the X-ray date in item 19.

Item 15. Leave blank. Not required by Medicare.

Item 16. Enter dates patient is employed and unable to work in current occupation. An entry in this field may indicate employment related insurance coverage.

Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring Physician: A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician: A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

The ordering / referring requirement became effective January 1, 1992, and is required by §1833(q) of the Social Security Act. All claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering / referring physician's name and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- ❑ Diagnostic laboratory services;
- ❑ Diagnostic radiology services;
- ❑ Consultative services; and
- ❑ Durable medical equipment.

Claims for other ordered / referred services not included in the preceding list must also show the ordering / referring physician's name and UPIN. For example, a surgeon must complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN must appear in items 17 and 17a.

All physicians must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a. When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

Enter the original ordering / referring physician's name and UPIN in items 17 and 17a of the first claim form.

Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form.

Surrogate UPINs: If the ordering / referring physician has not been assigned a UPIN, one of the surrogate UPINs listed below must be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a. All surrogate UPINs, with the exception of retired physicians (RET000), are temporary and may be used only until a UPIN is assigned. The Medicare carriers will monitor claims with surrogate UPINs.

The term "physician", when used within the meaning of §1861(r) of the Social Security Act, and used in connection with performing any function or action, refers to:

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he / she performs such function or action;

(2) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he / she performs such functions, and who is acting within the scope of his / her license when performing such functions;

(3) A doctor of podiatric medicine for purposes of subsections (k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii) and 1835, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

(4) A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

(5) A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for the purpose of §§1861(s)(1) and 1861(s)(2)(A), and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist). For the purposes of §1862(a)(4) and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4)) are furnished.

Item 17a. Enter the HCFA assigned (UPIN) of the referring/ordering physician listed in item 17. The first position of the UPIN must be alpha, the second and third alpha or numeric, and the last three, numeric.

When a claim involves multiple referring and/or ordering physicians, a separate HCFA-1500 must be used for each ordering/referring physician.

Use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited.

- ❏ Residents who are issued a UPIN in conjunction with activities outside of their residency status must use that UPIN. For interns and residents without UPINs, use the six (6) character surrogate UPIN RES000 for residents and INT000 for interns;
- ❏ Retired physicians who were not issued a UPIN may use the surrogate RET000;
- ❏ Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD000;
- ❏ Physicians serving in the Public Health or Indian Health Services may use PHS000; and
- ❏ The law extends coverage and direct payment in non-Metropolitan Statistical Areas to practitioners who are State licensed to order medical services or refer patients to Medicare providers without the approval or collaboration of a supervising physician. Use the surrogate UPIN "NPP000" on claims involving services ordered/referred by nurse practitioners, clinical nurse specialists, or any non-physician practitioner who is State licensed to order clinical diagnostic tests.
- ❏ When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH000" until an individual UPIN is assigned.

Item 18. Complete this item when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19. Enter the date the patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist, psychotherapist, or physician providing routine foot care submits claims.

Enter the X-ray date for chiropractor services. By entering an X-ray date, and the initiation date for course of chiropractic treatment in item 14, you are certifying that all the relevant information requirements of the MCM, §§2251 and 4118 are on file along with the appropriate X-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a coherent description of "unlisted procedure codes" if one can be given within the

confines of this box. Otherwise an attachment must be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1= (mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent lab renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See §§2051.1 and 2070.1H respectively, for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, "Testing for hearing aid" when submitting claims to obtain intentional denials when other payers are involved.

When dental exams are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed but only if HCPCS codes do not cover them.

Enter whether a "pump" or "reservoir" is used when HCPCS codes 63750 and/or 63780 are used.

Enter the assumed and relinquished date for a global surgery claim when providers share post-operative care.

Enter the statement, "Attending physician, not hospice employee" when a physician renders services to a hospice patient but the hospice in which the patient resides does not employ the physician.

Item 20. Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "no purchased tests are included on the claim". ***When "yes" is annotated, item 32 must be completed. When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.***

Item 21. Enter the patient's diagnosis / condition. The physician must use the ICD-9-CM code number. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

Item 22. Leave blank. Not required by Medicare.

Item 23. Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

Item 24a. Enter the month, day and year for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G.

Item 24b. Enter the appropriate place of service code from the list provided in §2010.3. Identify the location where the item is used or the service is performed.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24c. Medicare providers are not required to complete this item.

Item 24d. Enter the procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when you enter an unlisted procedure code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

Item 24e. Enter the diagnosis code reference number as shown in item 21, to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number

per line item. When multiple services are performed, enter the primary reference number for each service; ***either a 1, or a 2, or a 3, or a 4.***

Item 24f. Enter the charge for each listed service.

Item 24g. Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. *If only one service is performed, the numeral 1 must be entered.*

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24G. Convert hours into minutes and enter the total minutes required for this procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24g.

For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24g.

For units of portable contents only (i.e., no stationary gas or liquid system used) round to the nearest five feet or one liquid pound, respectively.

Item 24h. Leave blank. Not required by Medicare.

Item 24I. Leave blank. Not required by Medicare.

Item 24j. Leave blank. Not required by Medicare.

Item 24k. Enter the carrier assigned Provider Identification Number (PIN) when the performing physician / supplier is a member of a group practice.

When several different physicians or suppliers within a group are billing on the same HCFA-1500 form, show the individual PIN in the corresponding line item.

Item 25. Enter your physician / supplier Federal Tax I.D. (Employer Identification Number) or Social Security Number. The participating physician / supplier Federal Tax I.D. Number is required for a mandated Medigap transfer.

Item 26. Enter the patient's account number assigned by the physician's / supplier's accounting system. This is a physician / supplier optional field to enhance patient identification.

Item 27. Check the appropriate block to indicate whether the physician / supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in item 9 and MEDIGAP payment authorization is given in item 13, the physician / supplier must also be a Medicare participating physician or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.

The following Providers / Suppliers and claims can only be paid on an assignment basis:

- ❑ Clinical diagnostic laboratory services;
- ❑ Physician services to individuals dually entitled to Medicare and Medicaid;
- ❑ Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers;
- ❑ Ambulatory surgical center services; and
- ❑ Home dialysis supplies and equipment paid under Method II.

Item 28. Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29. ***Enter the total amount the patient paid on the covered services only.***

Item 30. ***Leave blank. Not required by Medicare.***

Item 31. Enter the signature of physician/supplier, or his representative, and the date the form was signed.

Item 32. Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. When the name and address of the facility where the services were furnished is the same as the billers name and address shown in item 33 enter the word "SAME." Physicians must identify the supplier's name, address and carrier assigned PIN when billing for purchased diagnostic tests. ***When more than one supplier is used, a separate HCFA-1500 should be used to bill for each supplier.***

This item is completed whether the supplier personnel performs the work at the physician's office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered must be entered if other than home. However, if the address shown in item 33 is in a HPSA and is the same as where the services were rendered, enter the word "SAME."

If the supplier is a certified mammography screening center, enter the 6 digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed and the carrier assigned PIN.

Item 33. Enter the physician/supplier's billing name, address, zip code, and telephone number.

Enter the carrier assigned PIN **(Not the HCFA assigned UPIN)** for the performing physician/supplier who is not a member of a group practice.

Enter the Group Number for the performing physician/supplier who is a member of a group practice.

Section 2

Place of Service Codes (POS) and Definitions

New Place of Service Codes. — The new HCFA-1500 POS codes, as well as a crosswalk to the "old" HCFA-1500 POS Codes are listed below. The current CWF POS codes are identical to those of the new HCFA-1500.

New HCFA-1500 (12/90):		Old HCFA-1500:
00-10	Unassigned	
11	Office	3 - (O)
12	Home	4 - (H)
13-20	Unassigned	
21	Inpatient Hospital	1 - (IH)
22	Outpatient Hospital	2 - (OH)
23	Emergency Room - Hospital	2 - (OH)
24	Ambulatory Surgical Center	B - (ASC)
25	Birthing Center	0 - (OL)
26	Military Treatment Facility	0 - (OL)
27-30	Unassigned	
31	Skilled Nursing Facility	8 - (SNF)
32	Nursing Facility	7 - (NH)
33	Custodial Care Facility	0 - (OL)
34	Hospice 0 - (OL)	
35-40	Unassigned	
41	Ambulance	Land
42	Ambulance	Air or Water
43-49	*Unassigned*	
50	*Federally Qualified Health Center*	
51	Inpatient Psychiatric Facility	0 - (OL)
52	*Psychiatric Facility Partial Hospitalization*	
53	Community Mental Health Center	
54	Intermediate Care Facility/ Mentally Retarded	D - (STF)
55	Residential Substance Abuse Treatment Facility	C - (RTC)
56	Psychiatric Residential Treatment Center	C - (RTC)
57-60	Unassigned	

61	Comprehensive Inpatient Rehabilitation Facility	0 - (OL)
62	Comprehensive Outpatient Rehabilitation Facility	E - (COR)
63-64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	F - (KDC)
66-70	Unassigned	
71	State or Local Public Health Clinic	0 - (OL)
72	Rural Health Clinic	0 - (OL)
73-80	Unassigned	
81	Independent Laboratory	A - (IL)
82-98	Unassigned	
99	Other Unlisted Facility	

POS Definitions

Codes Definitions

00-10 (Unassigned)

11 Office

Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

12 Patient's Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

13-20 (Unassigned)

21 Inpatient Hospital

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital

A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room - Hospital

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center

A free standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center

A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of new born infants.

26 Military Treatment Facility

A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27-30 (Unassigned)

31 Skilled Nursing Facility

A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility

A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice

A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 (Unassigned)

41 Ambulance-Land

A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 Ambulance Air or Water

An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43-49 (Unassigned)

50 Federally Qualified Health Center

A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center (CMHC)

A facility that provides the following services:

- ❑ Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility;
- ❑ 24 hour a day emergency care services;
- ❑ Day treatment, other partial hospitalization services, or psychosocial rehabilitation services;
- ❑ Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and
- ❑ Consultation and education services.

54 Intermediate Care Facility / Mentally Retarded

A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57-60 (Unassigned)

61 Comprehensive Inpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social

or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63-64 (Unassigned)

65 End Stage Renal Disease Treatment Facility

A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

66-70 (Unassigned)

71 State or Local Public Health Clinic

A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic

A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

73-80 (Unassigned)

81 Independent Laboratory

A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

82-98 (Unassigned)

99 Other Unlisted Facility

Other service facilities not identified above.

Section 3

Exhibit 1: User Print File Specifications

Line	Field	Literal Columns	Field Type*	Bytes	
1		Left printer alignment block	M	3	01-03
1		Right printer alignment block	M	3	76-78
3	1	Medicare	M	1	01
3	1	Medicaid	M	1	08
3	1	Champus	M	1	15
3	1	Champva	M	1	24
3	1	Group Health Plan	M	1	31
3	1	FECA Blk Lung	M	1	39
3	1	Other	M	1	45
3	1a	Insured's ID Number	A/N	29	50-78
5	2	Patient's Name (Last, First, MI)	A	29	01-29
5	3	Patient's Birth Date (Month)	N	2	31-32
5	3	Patient's Birth Date (Day)	N	2	34-35
5	3	Patient's Birth (Year)	N	2	37-38
5	3	Sex-Male	A	1	42
5	3	Sex-Female	A	1	47
5	4	Insured Name (Last, First, MI)	A	29	50-78
7	5	Patient's Address (No., Street)	A/N	29	01-29
7	6	Patient Relationship to Insured (Self)	M	1	33
7	6	Patient Relationship to Insured (Spouse)	M	1	38
7	6	Patient Relationship to Insured (Child)	M	1	42
7	6	Patient Relationship to Insured (Other)	M	1	47
7	7	Insured's Address (No., Street)	A/N	29	50-78
9	5	Patient's Address (City)	A	24	01-24
9	5	Patient's Address (State)	A	2	26-27
9	8	Patient Status (Single)	M	1	35
9	8	Patient Status (Married)	M	1	41

Line	Field	Literal Columns	Field Type*	Bytes	
9	8	Patient Status (OTher)	M	1	47
9	7	Insured's Address (City)	A	23	50-72
9	7	Insured's Address (State)	A	2	74-75
11	5	Patient's Address (Zip Code)	N	9	01-09
11	5	Patient's Area Code	N	3	15-17
11	5	Patient's Phone #	N	7	19-25
11	8	Patient Status (Employed)	M	1	35
11	8	Patient Status (Full Time Student)	M	1	41
11	8	Patient Status (Part Time Student)	M	1	47
11	7	Insured's Address (Zip Code)	N	9	50-58
11	7	Insured's Area Code	N	3	65-67
11	7	Insured's Phone #	N	7	69-75
13	9	Other Insured's Name (Last, First, MI)	A	29	01-29
13	11	Insured's Policy, Group or FECA Number	A/N	29	50-78
15	9a	Other Insured's Policy or Group Number	A/N	29	01-29
15	10a	Condition Related (Employment C/P, Yes)	M	1	35
15	10a	Condition Related (Employment C/P, No)	M	1	41
15	11a	Insured's Date of Birth (Month)	N	2	54-55
15	11a	Insured's Date of Birth (Day)	N	2	57-58
15	11a	Insured's Date of Birth (Year)	N	4	60-63
15	11a	Sex-Male	M	1	68
15	11a	Sex-Female	M	1	75
17	9b	Other Insured's Date of Birth (Month)	N	2	0203
17	9b	Other Insured's Date of Birth (Day)	N	2	0506
17	9b	Other Insured's Date of Birth (Year)	N	2	0809
17	9b	Sex Male	M	1	18
17	9b	Sex Female	M	1	24
17	10b	Condition Related (Auto Accident-Yes)	M	1	35
17	10b	Condition Related (Auto Accident-No)	M	1	41
17	10b	Condition Related (Place-State)	A	2	46-47
17	11b	Insured's Employer's Name or School Name	A	29	50-78
19	9c	Other Insured's Employer's Name or School	A/N	29	01-29
19	10c	Other Accident (Yes)	M	1	35
19	10c	Other Accident (No)	M	1	41
19	11c	Insured's Insurance Plan or Program Name	A	29	50-78
21	9d	Other Insured's Insurance Plan or Program Name	A/N	29	01-29
21	10d	Condition Relate (Reserved for Local Use)	A/N	18	31-48
21	11d	Another Benefit Health Plan (Yes)	M	1	52
21	11d	Another Benefit Health Plan (No)	M	1	57
25	12	Left Blank for Patient's Signature			
25	13	Left Blank for Insured's Signature			
27	14	Date of Current Illness, Injury, Pregnancy (Month)	N	2	02-03
27	14	Date of Current Illness, Injury, Pregnancy (Day)	N	2	05-06
27	14	Date of Current Illness, Injury, Pregnancy (Year)	N	2	08-09
27	15	First Date Has Had Same or Similar Illness (Month)	N	2	37-38
27	15	First Date Has Had Same or Similar Illness (Day)	N	2	40-41
27	15	First Date Has Had Same or Similar Illness (Year)	N	2	43-44
27	16	Dates Patient Unable to Work (From Month)	N	2	54-55
27	16	Dates Patient Unable to Work (From Day)	N	2	57-58
27	16	Dates Patient Unable to Work (From Year)	N	2	60-61
27	16	Dates Patient Unable to Work (To Month)	N	2	68-69

Line	Field	Literal Columns	Field Type*	Bytes	
27	16	Dates Patient Unable to Work (To Day)	N	2	71-72
27	16	Dates Patient Unable to Work (To Year)	N	2	74-75
29	17	Name of Referring Physician or Other Source	A	26	01-26
29	17a	ID Number of Referring Physician	A/N	21	28-48
29	18	Hospitalization Related Current Svcs (From Month)	N	2	54-55
29	18	Hospitalization Related Current Svcs (From Day)	N	2	57-58
29	18	Hospitalization Related Current Svcs (From Year)	N	2	60-61
29	18	Hospitalization Related Current Svcs (To Month)	N	2	68-69
29	18	Hospitalization Related Current Svcs (To Day)	N	2	71-72
29	18	Hospitalization Related Current Svcs (To Year)	N	2	74-75
31	19	Reserved for Local Use	A/N	48	01-48
31	20	Outside Lab (Yes)	M	1	52
31	20	Outside Lab (No)	M	1	57
31	20	$ Charges	N	7	62-68
33	21.1	Diagnosis or Nature of Illness or Injury (Code)	N	3	03-05
33	21.1	Diagnosis or Nature of Illness or Injury (Code)	N	2	07-08
33	21.1	Diagnosis	A	20	10-29
33	21.3	Diagnosis or Nature of Illness or Injury (Code)	N	3	31-33
33	21.3	Diagnosis or Nature of Illness or Injury (Code)	N	2	35-36
33	21.3	Diagnosis	A	11	38-48
33	22	Medicaid Resubmission Code	N	8	53-60
33	22.2	Original Reference Number	N	13	66-78
35	21.2	Diagnosis or Nature of Illness or Injury (Code)	N	3	03-05
35	21.2	Diagnosis or Nature of Illness or Injury (Code)	N	2	07-08
35	21.2	Diagnosis	A	20	10-29
35	21.4	Diagnosis or Nature of Illness or Injury (Code)	N	3	31-33
35	21.4	Diagnosis or Nature of Illness or Injury (Code)	N	2	35-36
35	21.4	Diagnosis	N	11	38-48
35	23	Prior Authorization Number	A/N	29	50-78
39	24.1a	Date(s) of Service (From Month)	N	2	01-02
39	24.1a	Date(s) of Service (From Day)	N	2	04-05
39	24.1a	Date(s) of Service (From Year)	N	2	07-08
39	24.1a	Date(s) of Service (To Month)	N	2	10-11
39	24.1a	Date(s) of Service (To Day)	N	2	13-14
39	24.1a	Date(s) of Service (To Year)	N	2	16-17
39	24.1b	Place of Service	A/N	2	19-20
39	24.1c	Type of Service	A/N	2	22-23
39	24.1b	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
39	24.1c	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
39	24.1c	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
39	24.1e	Diagnosis Code	A/N	6	42-47
39	24.1f	$ Charges	N	5	50-54
39	24.1f	$ Charges	N	2	56-57
39	24.1g	Days or Units	N	2	59-60
39	24.1h	EPSDT Family Plan	A/N	2	62-63
39	24.1i	EMG	A/N	2	65-66
39	24.1j	COB	A/N	2	68-69
39	24.1k	Reserved for Local Use	A/N	8	71-78
41	24.2a	Dates of Service (From Month)	N	2	01-02
41	24.2a	Dates of Service (From Day)	N	2	04-05
41	24.2a	Dates of Service (From Year)	N	2	07-08
41	24.2a	Dates of Service (To Month)	N	2	10-11
41	24.2a	Dates of Service (To Day)	N	2	13-14
41	24.2a	Dates of Service (To Year)	N	2	16-17

Line	Field	Literal Columns	Field Type*	Bytes	
41	24.2b	Place of Service	A/N	2	19-20
41	24.2c	Type of Service	A/N	2	22-23
41	24.2d	Procedures, Scvs or Supplies (CPT/HCPCS)	A/N	5	26-30
41	24.2d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
41	24.2d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
41	24.2e	Diagnosis Code	A/N	6	42-47
41	24.2f	$ Charges	N	5	50-54
41	24.2f	$ Charges	N	2	56-57
41	24.2g	Days or Units	N	2	59-60
41	24.2h	EPSDT Family Plan	A/N	2	62-63
41	24.2i	EMG	A/N	2	65-66
41	24.2j	COB	A/N	2	68-69
41	24.2k	Reserved for Local Use	A/N	8	71-78
43	24.3a	Dates of Service (From Month)	N	2	01-02
43	24.3a	Dates of Service (From Day)	N	2	04-05
43	24.3a	Dates of Service (From Year)	N	2	07-08
43	24.3a	Dates of Service (To Month)	N	2	10-11
43	24.3a	Dates of Service (To Day)	N	2	13-14
43	24.3a	Dates of Service (To Year)	N	2	16-17
43	24.3b	Place of Service	A/N	2	19-20
43	24.3c	Type of Service	A/N	2	22-23
43	24.3d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
43	24.3d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
43	24.3d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
43	24.3e	Diagnosis Code	A/N	6	42-47
43	24.3f	$ Charges	N	5	50-54
43	24.3f	$ Charges	N	2	56-57
43	24.3g	Days or Units	N	2	59-60
43	24.3h	EPSDT Family Plan	A/N	2	62-63
43	24.3i	EMG	A/N	2	65-66
43	24.3j	COB	A/N	2	68-69
43	24.3k	Reserved for Local Use	A/N	8	71-78
45	24.4a	Dates of Service (From Month)	N	2	01-02
45	24.4a	Dates of Service (From Day)	N	2	04-05
45	24.4a	Dates of Service (From Year)	N	2	07-08
45	24.4a	Dates of Service (To Month)	N	2	10-11
45	24.4a	Dates of Service (To Day)	N	2	13-14
45	24.4a	Dates of Service (To Year)	N	2	16-17
45	24.4b	Place of Service	A/N	2	19-20
45	24.4c	Type of Service	A/N	2	22-23
45	24.4d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
45	24.4d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
45	24.4d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
45	24.4e	Diagnosis Code	A/N	6	42-47
45	24.4f	$ Charges	N	5	50-54
45	24.4f	$ Charges	N	2	56-57
45	24.4g	Days or Units	N	2	59-60
45	24.4h	EPSDT Family Plan	A/N	2	62-63
45	24.4i	EMG	A/N	2	65-66
45	24.4j	COB	A/N	2	68-69
45	24.4k	Reserved for Local Use	A/N	8	71-78
47	24.5a	Dates of Service (From Month)	N	2	01-02
47	24.5a	Dates of Service (From Day)	N	2	04-05
47	24.5a	Dates of Service (From Year)	N	2	07-08
47	24.5a	Dates of Service (To Month)	N	2	10-11
47	24.5a	Dates of Service (To Day)	N	2	13-14
47	24.5a	Dates of Service (To Year)	N	2	16-17
47	24.5b	Place of Service	A/N	2	19-20
47	24.5c	Type of Service	A/N	2	22-23

Line	Field	Literal Columns	Field Type*	Bytes	
47	24.5d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
47	24.5d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
47	24.5d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
47	24.5e	Diagnosis Code	A/N	6	42-47
47	24.5f	$ Charges	N	5	50-54
47	24.5f	$ Charges	N	2	56-57
47	24.5g	Days or Units	N	2	59-60
47	24.5h	EPSDT Family Plan	A/N	2	62-63
47	24.5i	EMG	A/N	2	65-66
47	24.5j	COB	A/N	2	68-69
47	24.5k	Reserved for Local Use	A/N	8	71-78
49	24.6a	Dates of Service (From Month)	N	2	01-02
49	24.6a	Dates of Service (From Day)	N	2	04-05
49	24.6a	Dates of Service (From Year)	N	2	07-08
49	24.6a	Dates of Service (To Month)	N	2	10-11
49	24.6a	Dates of Service (To Day)	N	2	13-14
49	24.6a	Dates of Service (To Year)	N	2	16-17
49	24.6b	Place of Service	A/N	2	19-20
49	24.6c	Type of Service	A/N	2	22-23
49	24.6d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
49	24.6d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
49	24.6d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
49	24.6e	Diagnosis Code	A/N	6	42-47
49	24.6f	$ Charges	N	5	50-54
49	24.6f	$ Charges	N	2	56-57
49	24.6g	Days or Units	N	2	59-60
49	24.6h	EPSDT Family Plan	A/N	2	62-63
49	24.6i	EMG	A/N	2	65-66
49	24.6j	COB	A/N	2	68-69
49	24.6k	Reserved for Local Use	A/N	8	71-78
51	25	Federal Tax ID Number	N	15	1-15
51	25	Federal Tax ID Number (SSN)	M	1	17
51	25	Federal Tax ID Number (EIN)	M	1	19
51	26	Patient's Account Number	A/N	14	23-36
51	27	Accept Assignment (Yes)	M	1	38
51	27	Accept Assignment (No)	M	1	43
51	28	Total Charge (Dollars)	N	6	51-56
51	28	Total Charge (Cents)	N	2	58-59
51	29	Amount Paid (Dollars)	N	5	62-66
51	29	Amount Paid (Cents)	N	2	68-69
51	30	Balance Due (Dollars)	N	5	71-75
51	30	Balance Due (Cents)	N	2	77-78
53	32	Name of Facility Where Svcs Rendered	A/N	25	23-47
53	33	Physician/Supplier Billing Name	A/N	29	50-78
54	32	Address of Facility Where Svcs Rendered	A/N	25	23-47
54	33	Physician/Supplier Address	A/N	29	50-78
55	31	Left Blank for Signature Physician/Supplier			
55	32	Address of Facility Where Svcs Rendered	A/N	25	23-47
55	33	Zip Code/Phone # of Physician/Supplier	A/N	29	50-78
55	32	Address of Facility Where Svcs Rendered	A/N	25	23-47
56	33	Physician/Supplier PIN #	A/N	10	52-61
56	33	Physician/Supplier GRP Number	A/N	12	67-78

* *M = mark (X), A = alpha, N = numeric*

Exhibit 2: Printing Standards

A revision of form HCFA-1500 Specifications first issued by GPO for distribution with the negatives. These include the original HCFA-1500 (12/90) Printing Standards given to the Government Printing Office.

The form HCFA-1500 (12-90) is designed to accommodate 10-pitch Pica type, 6 lines per inch. Once adjusted to the left and right, PICA alignment blocks in the first print line and characters appear within form lines as shown in the print file matrix.

Also, provided on the form HCFA-1500 (12-90) is a typewriter alignment bar. This is the thick horizontal line that is at the base of the PICA alignment boxes.

The form HCFA-1500 (12-90) is used in four different styles. Any one of these four styles may be printed from two negatives provided by the US Government Printing Office. (GPO) The face negative furnished must be used for Parts 1 and 2. The back negative furnished must be used for Part 1 only.

The Printing Standards in Exhibit 4 are used in conjunction with the negatives provided by GPO. Compliance with these standards is required to facilitate the use of image processing technology such as Optical Character Recognition, facsimile transmission, and image storage.

Checks or money orders for the purchase of the negatives from the US GPO are to be made payable to the Public Printer and sent to:

Asst. Supt., Dept. of Acct., Rep. Div.
USGPO Room
Room C-830
Washington DC 20401
or
call (202) 512-1800

Cut Sheet:

Size	8 1/2 inches (plus or minus 0.1 inch) by 11 inches (plus or minus 1/6 inch). 217mm by 281mm plus or minus 2mm.
Print	Face and back, head to head.
Margins	Face - The top margin from the top edge of the form to the typewriter alignment bar is 1 1/3 inches or 34mm. The left margin is 0.3 inch to the left end of the typewriter alignment bar. Back - 0.25 inch head and foot, 0.25 inch left and right. Offset - The X and Y offset for margins must not vary by more than +/- 0.1 inch from sheet to sheet. The X offset refers to the horizontal distance from the left edge of the paper to the beginning of the printing. The Y offset refers to the vertical distance between the top of the paper and the beginning of the printing.
Askewity	The askewity of the printed image must be no greater than 0.15mm in 100mm.
Stock	White, OCR Bond, 20 lbs., equal to JCP-O-25. Cut square with each corner 90 degrees, plus or minus 0.025 degrees.
Ink Color	Face - Sinclair Valentine J6983, OCR red or equal. Back - Same as face.

Two Part Snapset:

Size	Same dimensions as for Cut Sheet (detached 8.5" by 11"), plus top stub (0.5" - 0.75").
Print	Part 1 - Face and back, head to head. Part 2 - Face only. (Instructions print on the back of Part 1 only.)
Margins	Same as for Cut Sheet.
Askewity	Same as for Cut Sheet.
Stock	Part 1 - Same as for Cut Sheet. Part 2 - Any color or weight that will not interfere with scanning of the Part 1 sheet.
Ink Color	Part 1 - Same as for Cut Sheet. Part 2 - Any color that will not interfere with scanning of the Part 1 sheet.
Perforations	Perforate top stub along 8.5" X dimension for disassembly of parts. Do not perforate carbons.

Carbon	Black one time of sufficient quality to ensure legibility of Part 2. To extend to within 0.5" of bottom of detached sheet. Carbon impression must be clear and sharp without smearing or smudging.

One Part Marginally Punched Continuous Form:

Size	Same dimensions as for Cut Sheet, plus 0.5" left and right, (Overall: 9.5" by 11", detached: 8.5" by 11").
Print	Face and back, head to head.
Margins	On detached sheet, same as for Cut Sheet.
Askewity	On detached sheet, same as for Cut Sheet.
Stock	Same as for Cut Sheet.
Ink Color	Same as for Cut Sheet.
Perforations	Marginally 1/2" left and right, tearline horizontally every 11".

Two Part Marginally Punched Continuous Form:

Size	Same dimensions as for Cut Sheet, plus 1/2" left and right, (overall: 9.5" x 11", detached: 8.5" x 11").
Print	Part 1 - Face and back, head to head. Part 2 - Face only, head to head (Instructions print on the back of Part 1 only.)
Margins	On detached sheet, same as for Cut Sheet.
Askewity	On detached sheet, same as for Cut Sheet.
Stock	Part 1 -Same as for Cut Sheet. Part 2 -Any color or weight that does not interfere with scanning of the Part 1 sheet.
Ink Color	Part 1 -Same as for Cut Sheet. Part 2 -Any color that will not interfere with scanning of the Part 1 sheet.
Perforations	Marginally 1/2" left and right, tearline horizontally every 11".
Carbon	Black one time of sufficient quality to ensure legibility of Part 2. To extend to within 1/2" of bottom of detached sheet. Carbon impression must be clear and sharp without smearing or smudging.
Joining	Crimp left and right

Exhibit 3: Printing Overlay Standards

Includes registration marks, forms identification, provider identification, and other overlay (second color) information that may be preprinted within the body of the form or in the white space at the top of the form. It may also include the bar codes used by some carriers.

No modification is to be made to the form HCFA-1500 (12/90) without prior approval of the Health Care Financing Administration.

Second color overlays (other than red) may be printed on the form if they comply with the following specifications:

Registration Lines	One inch perpendicular lines on the corners of body of form. Other registration methods (e.g., cornerstones) will be considered for approval.
Form Identification	Bottom Left of form contains the OMB approval number (APPROVED OMB-0938-0008). A quick scan determines which forms definition to use for the rest of the scan. The carrier name and address areas and white space in the upper right of the form and above the bar code may be used for a form identifier. Standard fonts (such as OCR-B), bar codes, and other widely recognized formats will be considered for approval.
Bar Codes	The left side of the top portion of the form, within the area designated "CARRIER", may be used to designate a place for a unique bar code. The application must start no less than 30mm from the left edge of the Cut Sheet, and no more than 90mm from the same left edge and extend no lower than 2mm above the typewriter alignment bar.

Carrier Name and Address — The right side of the top portion of the form, within the area designated "CARRIER", may be used by the carrier for printing customized names and addresses, and/or imprinting document control numbers. The area must be limited to extend no lower than 2mm above the label "HEALTH INSURANCE CLAIM FORM".

Printer Identification — Printers' names must appear in the bottom margin, starting below the left vertical line of the cut sheet. A small logo may appear with the name.

Item 33 — When using 10 pitch PICA type, item 33 contains room for 3 lines of 29 characters each, plus room for a PIN # of 10 positions and a GRP # of 12 positions. Normally, name, street address, city and state, and ZIP and phone number require at least 4 lines.

The five-digit ZIP code provides enough information to identify both city and state; in some cases, the nine-digit ZIP code can also replace the street address.

Line 1:Physician/Suppliers billing name.

Line 2: Street Address with City and State, if room.

Line 3: positions 1-11:
9 digit ZIP code with hyphen,

positions 14-29:
10 digit phone number with hyphens and extension.

Example:

Line 1_Dr. Jonas Salk

Line 2_6325 Security Blvd Balto MD

Line 321208-8888 410-555-9999x1234

Line 4__XPIN99xxxx___GROUPNUMBER9

Summer's Here; Flu Season is Not Far Behind

Editorial Note: The following article is for your information. These claims are not to be submitted to the DMERC. Please submit influenza virus vaccination claims to your local Part B carrier.

The Health Care Financing Administration (HCFA) is urging all individuals and entities meeting state licensure requirements to make a special effort, during the upcoming flu season, to offer the influenza virus vaccination to individuals enrolled in Part B of the Medicare program. For coverage purposes, Medicare does not require that the vaccine be ordered by a doctor of medicine or osteopathy; therefore, a beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. However, the provider of flu shots, must have a Medicare provider number in order to bill Medicare for payment. Medicare generally will pay each flu season, for only one flu shot per beneficiary.

Part B reimburses for the influenza vaccine and its administration **at 100 percent of the Medicare allowed amount**. The Part B deductible and coinsurance does not apply.

On unassigned claims, the beneficiary's responsibility is the difference between the amount actually billed and the amount Medicare pays.

For Medicare Health Maintenance Organization (HMO) members, Medicare will pay only when they receive their flu shots at their HMO. All HMOs provide flu shots; therefore, beneficiaries who are members of managed care plans should receive their flu shots from their managed care networks. Managed care enrollees should call their plans for further information.

Call your local carrier for more information about any aspect of the Medicare influenza virus vaccination benefit.

Summer's Here; Flu Season is Not Far Behind (Cont'd)

Roster Billing

Nonparticipating physicians and suppliers are not required to accept assignment when billing Medicare for the influenza virus vaccination and/or its administration when using standard billing procedures. We remind you that entities which undertake mass immunization programs may be eligible to use the "simplified" billing process referred to as roster billing, provided that they accept assignment as a qualifying condition.

The simplified (roster) billing process is available and was developed to enable Medicare beneficiaries to participate in mass influenza vaccination programs offered by public health clinics and other non-institutional entities that bill the Medicare carriers and institutional entities that bill the Medicare intermediaries.

This action was influenced by agency knowledge that the public health clinics and other non-institutional entities generally lack the requisite resources (budget, staff, time) to submit a separate Medicare form HCFA-1500 for each Medicare beneficiary for whom they administer a flu shot.

Currently, Public Health Clinics (PHCs) and other properly licensed individuals and entities conducting mass immunization programs can use a simplified claims filing procedure. They can bill carriers for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment as payment in full and cannot "balance bill" the beneficiary for these services.

Also, HCFA has expanded the simplified (roster) billing procedures for the influenza virus vaccine to mass immunizers that bill intermediaries such as hospital outpatient departments and Home Health Agencies.

The simplified process involves the use of the provider billing form (HCFA-1450) or (HCFA-1500) with preprinted standardized information relative to the provider and the benefit. Mass immunizers that bill intermediaries or carriers attach a standard roster to a single pre-printed HCFA-1450 or HCFA-1500 which contains the variable claims information regarding the service provider and the individual beneficiaries. Intermediaries/carriers use the beneficiary roster list to generate HCFA-1450s/1500s to process influenza claims by mass immunizers.

Utilize the roster billing procedures for this and all future flu seasons.

Electronic Claims

Billing electronically is fast, easy and convenient. All you need is a computer capable of running DOS software and a modem. The advantages of billing electronically are significant.

- ❑ **Electronic claims are paid quicker than paper claims. Medicare law requires payment to be made no sooner than the 27th day on paper claims; however, electronic claims can be paid after 13 days.**
- ❑ **Claim transmission 24 hours a day, 365 days a year. Computer lines are always open, you can transmit claims whenever you want. The 13 day payment floor time begins on the first business day your claims are received.**
- ❑ **No HCFA 1500 form fees, postage fees, mail time, or staff paper handling time. Your staff is free from mundane tasks and will have more time to focus on your practice.**
- ❑ **Toll free transmission lines. If you are a participating physician or supplier you can use a toll free number.**
- ❑ **ERN and EFT available. All providers transmitting 90% of their claims electronically can choose the option of electronic remittance advice with electronic funds deposit.**

Note to Physicians

We encourage you to accept assignment for the influenza virus vaccination, but assignment is not mandatory.

If the sole purpose of the patient's visit is to receive the influenza virus vaccine, you may not charge for an office visit. If, on the other hand, you render other services which may accurately be described by an evaluation and management code, you may bill for those services separately.

Call your local carrier for more information about any aspect of the Medicare influenza virus vaccination benefit.

Miscellaneous

A Healthy PC - Virus Scan Reminder

MetraHealth Medicare would like to remind you that it is important to virus scan all diskettes coming into or leaving your office. If you do not have a virus scanning utility, you can acquire one at your local PC software store. It is also important that you continue to keep the virus scanning utility current with the latest releases.

New Interest Rate

The Treasury Department has advised Medicare that effective July 1, 1996, the Prompt Payment interest rate on clean claims not paid timely will be 6.375 percent. The new rate will be effective for scheduled Medicare payment dates of July 1 through December 31, 1995.

Action Code 880

If you have a Medicare Claim denied due to a Medicare Secondary Payer reason with Action Code 880, please **do not submit a new claim**, as this will deny as a duplicate. Send a copy of our denial, along with the appropriate copy of the primary insurance explanation of benefits, to the attention of the MSP Unit. The original claim will then be adjusted accordingly for proper payment.

Billing Reminder

When billing for a special or custom wheelchair (codes K0008, K0009, K0013, or K0014), include the name brand, model number and a complete breakdown of parts and their codes.

Also, if billing for a miscellaneous code (A4335, A4421, A4649, E1399, K0108, L1499, L2999, L3649, L3999, L5999, L7499, and L8499), include the manufacturer, part number and / or description when it applies. This will prevent delays in reimbursement. **Failure to do so may result in a denial.**

ICD-9-CM Diagnosis Codes

Medicare will accept 1996 ICD-9-CM diagnosis codes on claim(s) received on or after October 1, 1995. From October 1, 1995 through December 31, 1995, codes may be used from either the 1995 or 1996 version of ICD-9-CM.

All claims received on or after January 1, 1996 **must** contain the 1996 version of ICD-9-CM diagnosis codes.

ICD-9-CM Coding Book, Fourth Edition, Volume 1 & 2

The 1996 version can be purchased from the following:

CD ROM Version

Superintendent of Documents
U.S. Government Printing Office
P. O. Box 371954
Pittsburgh, PA 15250

Phone: (202) 512-1800
FAX: (202) 512-2250
Cost: $18.00

MasterCard and Visa credit cards are acceptable. Indicate the card number and expiration date.

Paper Version

Department of Health and Human Services
Public Health Service
National Center for Health Statistics
6525 Belcrest Road
Hyattsville, MD 20782

The 1996 prices are subject to periodic increases.