



**DENVER
HEALTH**

Medical Plan, Inc.

DENVER HEALTH MEDICAL PLAN, INC.

1500 Claims Processing Manual

DHMP Health Insurance Claim Form CMS-1500

Box 1 – Medicare, Medicaid, Group Health Plan or other insurance Information

Show the type of health insurance coverage applicable to this claim by checking the appropriate box. When DHMP (Group Health Plan)

Box 1a – Insured's ID Number

Enter the patient's DHMP Health Insurance ID Number

This is a required field

Box 2 – Patient's Name (Last Name, First Name, Middle Initial)

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

This is a required field

Box 3 – Patient Birth Date

Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

This is required field

Box 4 – Insured's Name (Last Name, First Name, Middle Initial)

List the name of the insured here. When the insured and the patient are the same
Enter the word the SAME

Box 5 – Patient's Address (Number, Street)

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.

Box 6 – Patient Relationship to Insured

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

This is a required field

Box 7 – Insured's Address (Number, Street)

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 Box -4, 6, and 11 are completed

Box 8 – Patient Status

Check the appropriate box for the patient's marital status and whether Single or Married, Employed or Student

This is a required field

Box 9 – Other Insured's name (Last Name, First Name, Middle Initial)

Enter the last name, first name, and middle initial of the enrollee if policy is different

This field may be used in the future for supplemental insurance plans.

Box 9a – Other Insured's policy or Group Number

Enter the other policy and/or group number of the other insurance.

This Box must be completed if applicable

Box 9b – Other Insured's Date of Birth

Enter the other insured's 8-digit birth date (MM | DD | CCYY) and sex.

This Box must be completed if applicable

Box 9c –Employer's Name or School Name

Enter Employer's name or school name.

This Box must be completed if applicable

Box 9d – Insurance Plan Name or Program Name

Name of the insurance plan Name

This Box must be completed if applicable

Box 10a through 10c – Is patient's Condition Related to:

Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Box 24

This is a required field

Box 10d – Reserved for Local use

Not applicable

Box 11 – Insured’s Policy Group Number

This Box must be completed if applicable

NOTE: Enter the appropriate information in item 11c if insurance primary to DHMP is indicated in Box 11.

If there is insurance primary to DHMP, enter the insured's policy or group number and proceed to Box 11a-11c. Box 4, 6 and 7 must be completed

If there is no insurance primary to DHMP, enter the word "NONE" and proceed to Box 12

If the insured reports a terminating event with regard to insurance which had been primary to DHMP (e.g., insured retired), enter the word "NONE" and proceed to Box 11b

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word “None” in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to DHMP

Circumstances under which DHMP payment may be secondary to other insurance:

- Group Health Plan Coverage through spouse working aged
- Disability (Large Group Health Plan)
- End Stage Renal Disease
- No Fault and/or Other Liability
- Work-Related Illness/Injury
- Workers' Compensation
- Black Lung
- Veterans Benefits

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

Box 11a – Insured’s Date of Birth

Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from Box 3

Box 11b – Employer’s Name or School Name

Enter employer's name, if applicable.

If there is a change in the insurance status, such as retired, enter a 6-digit (MM | DD | YY) or 8-digit (MM | DD CCYY) retirement date preceded by the word "RETIRED."

Box 11c- Insurance Plan Name or Program name

Enter the 9-digit PAYER ID number of the primary insurer. If no PAYER ID number exists, then enter the complete primary payer's program or plan name.

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. This is required if there is insurance primary to DHMP which is indicated In Box 11.

Box 11d – Is there another Health Benefit Plan?

This Box must be completed if applicable

Box 12 –Patient’s or Authorized Person’s Signature

The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 2008) unless the signature is on file.

NOTE: This can be "Signature on File" and/or a computer generated signature. The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or 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.

Box 13 – Insured’s or Authorized Person’s Signature

The patient’s signature or the statement “signature on file” in this Box authorizes payments of medical benefits to the physician or supplier.

The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment related basis or when payment is for services furnished by a participating physician or supplier, a patient’s signature or a “signature on file” is not required in order for DHMP payment to be made directly to the physician or supplier.

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

Box 14 – Date of Current:

Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy.

Box 15 –If Patient has had the same or similar Illness

This Box must be completed if applicable

Box 16 – Dates Patient unable to work in current occupation

If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Box 17 – Name of Referring Provider or Other Source

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

Box 17a – Leave blank

NOTE: Effective **May 23, 2008**, 17a is not to be reported but 17b **MUST** be reported when a service was ordered or referred by a physician.

Box17b Form CMS-1500 – NPI

Enter the NPI of the referring/ordering physician listed in Box 17

All physicians who order services or refer DHMP beneficiaries must report this data

This is a required field

Box 18 –Hospitalization Dates Related to Current Services

Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Box 19 – Reserved for Local Use

This Box must be completed if applicable

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item

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.

Box 20 – Outside Lab

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 "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price Limitations.

Box 21 – Diagnosis or Nature of Illness Injury

Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and non physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order

This a required field

Box 22 – Medicaid Resubmission Code

Not applicable

Box 23 – Prior Authorization Number

Enter the DHMP prior authorization number for those procedures that requires DHMP prior approval

Box 24A – Date(s) of Service

Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service or supply

This is a required field

Box 24B – Place of Service

Enter the appropriate place of service code(s) from the list provided in Identify the location, using a place of service code, for each item used or service performed:

- 11- Clinic
- 12- Home
- 21- Inpatient Hospital
- 22- Outpatient Hospital
- 23- Emergency Room
- 24- Ambulatory Surgery
- 41- Ambulance
- 50- FQHC
- 65-End stage renal disease treatment

This a required field

Box 24C – EMG

This Box must be completed if applicable

Box 24D – Procedures, Services, or Supplies CPT/HCPCS Modifiers

Enter the procedures, services, or supplies using the Healthcare Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS).

When applicable, show CPT/ HCPCS modifiers with CPT/HCPCS code.

The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific CPT/HCPCS procedure code without a narrative description.

However, when reporting an "unlisted procedure code or “Not otherwise classified” (NOS) include a narrative description in Box 19, if a coherent description can be given, within the confines of that box. Otherwise, an attachment should be submitted with the claim.

This is a required field

Box 24E – Diagnosis Pointer

Enter the diagnosis code reference number as shown in Box 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.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

This is a required field

Box 24F- \$ Charges

Enter the charge for each listed service.

This is a required field

Box 24G – Days or units

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.

This is a required field

NOTE: This field should contain at least 1 day or unit. The carrier should program their system to automatically default to "1" unit when the information in this field is missing to avoid returning claims as unprocessable.

Box 24H – EPSDT Family Plan

Not applicable

Box 24J – Rendering Provider NPI

Enter the rendering provider’s NPI number in the lower **unshaded** portion.

This is a required field

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Box 25 – Federal Tax ID Number

Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. DHMP providers are required to complete this item for crossover purposes.

Tax identification information is used in the determination of accurate National Provider Identifier (NPI) reimbursement.

Reimbursement of claims submitted without tax identification information will/may be delayed.

This is a required field

Box 26 – Patient’s Account Number

Enter the patient's account number assigned by the provider's of service or supplier's accounting system.

This field is required field to assist the provider in patient identification.

Box 27 – Accept Assignment? Yes or NO?

Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of DHMP benefits. The provider of service or supplier shall also be a DHMP participating provider of service or supplier and accept assignment of DHMP benefits for all covered charges for all patients.

This is a required field

Box 28 – Total Charge

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

This is a required field

Box 29 – Amount Paid

Enter the total amount the patient paid on the covered services only.

This Box must be completed if applicable

Box 30 – Balance Due

This Box must be completed if applicable

Box 31 – Signature of Physician or Supplier

Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed

NOTE: This is a required field. However the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Box 32 – Service Facility Location Information

Enter the name and address, and ZIP Code 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.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only).

When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

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.

This is a required field

Box 32a – Service Facility Location Information

Required by DHMP for claims processing policy, enter the NPI of the service facility If applicable

Box 32b - *Effective May 23, 2008, Item 32b is not to be reported.*

Box 33 – Billing Provider Info & PH Number

Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number.

This is a required field.

Box 33a – Billing Provider Info & PH Number

Enter the NPI of the billing provider or group.

This is a required field.

Box 33b - *Effective May 23, 2008, Item 33b is not to be reported.*