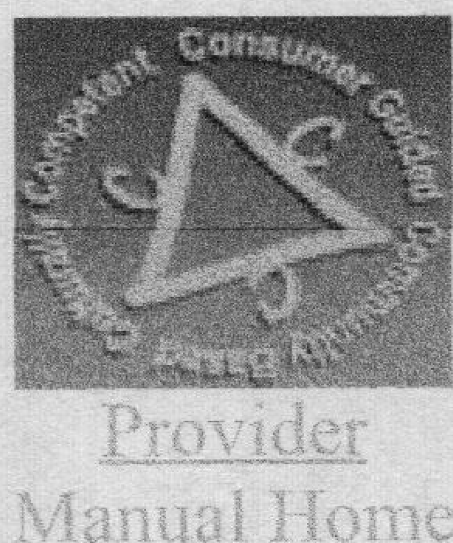

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HCFA 1500 Claim Form and Directions

You can Download a pdf version of the HCFA Claim Form, and also a 35-page instruction book for filling out the form. You can download the Acrobat Reader, if you do not already have it, free from Adobe.

Otherwise, here is an abridged version of instructions to fill out the HCFA 1500 Claim Form:

Required fields on the form are marked "**REQUIRED**".

Patient Information (blocks 2-8). **REQUIRED**

Box 2 - Last Name, First Name, Middle Initial (if any)
Box 3 - Date of Birth and Sex
Box 4 - Medi-Cal Beneficiary Name (if different than the name in block 2)
Box 5 - Patient's Address
Box 6 - Patient's Relationship to Insured (used in conjunction with information on block 9)
Box 7 - Insured Address (used in conjunction with information on block 9)
Box 8 - Patient's Marital and Work Status

Other insurance information (blocks 9-9d) - This section is completed if the Patient has other insurance. **REQUIRED**

Box 9 - Other Insured's Name. Enter the last name, first name, and middle initial of the enrollee in the other insurance policy
9a - Other Insured's Policy or Group Number
9b - Other Insured's Date of Birth, Sex
9c - Other Insured's Employer's Name
9d - Insurance Plan Name or Program Name

Please see under Section X, Claims Processing and Payment, Coordination of Benefits, for more information. SFMHP is the payor of last resort; therefore, claims for patients who are covered under Medi-Cal and another insurance plan must include a copy of the insurance Explanation of Benefits or Claim Denial Letter in order for SFMHP to determine payment liability. Medicare/Medi-Cal crossover claims are sent to the State's fiscal intermediary (EDS) or the Medicare fiscal intermediary. They are not processed by the SFMHP Claims Unit.

Patient's Condition (blocks 10a-c) - Is the Patient's condition related to Employment? Auto Accident? Other Accident? **REQUIRED**

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. Any item checked "YES" indicates there may be other insurance primary to MediCal. Identify primary insurance information on Item 11.

Enter the State postal code (i.e.: CA for California)

Patient Signatures (blocks 12-13) **REQUIRED**

Box 12 - Release of Information: Patient's or Authorized Person's Signature

Box 13 - Assignment of Benefit: Insured or Authorized Person's Signature

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Comments (block 19)

Free-form "comments" field to insert additional claim information not designated to appear in another block.

Diagnosis Coding (block 21) **REQUIRED**

Enter the patient's DSM IV diagnosis.

No narrative information is needed in block 21.
Document the condition(s) to the highest degree of specificity.

Prior Authorization Number (block 23) **REQUIRED**

Record the Authorization number issued by the ACCESS Team for the services being claimed.

Dates of Service (block 24A) **REQUIRED**

Enter the month, day, and year for each procedure or service. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in block 24d. If the "from" and "to" dates of services are the same, code only the "from date" of service using the appropriate six-digit format (e,g,: 010197)

Do not date range services in different months on one detail line. Instead, you must split up the dates, prorating the charges and quantity billed appropriately.

Place of Service (block 24B) **REQUIRED**

Enter the appropriate place of service code (list follows these instructions). Make sure that the procedure code you are using matches the place of service. For example, do not bill 99220 (Hospital Observation Care:Initial Problem = High) with a place of service code 11 (Office). List the name and address of the facility where service was rendered on block 32.

Use the 2 digit code only - do not use abbreviations such as "O" for Office, etc.

Procedure Code (block 24d) **REQUIRED**

Enter the authorized HCPCS (HCFA Common Procedure Coding System) codes listed in the authorization letter.

Diagnosis Pointer (block 24E) **REQUIRED**

Enter the diagnosis code reference number as shown in block 21, to relate the date of service and the procedures performed to the appropriate diagnosis.

Do not use DSM IV codes in this block. Use only the reference number(s) from block 21.

$ Charges (block 24F) **REQUIRED**

Enter the charge for each item.

Days or Units of Service (block 24G) **REQUIRED**

Enter the number of days or units. When multiple services are provided, enter the actual number provided.

EPSDT Service (block 24H)

Check if the service being claimed is an EPSDT procedure.

COB - Coordination of Benefits (block 24J)

Check if the service is covered by another insurance carrier. Please attach an Explanation of Benefits form showing this service was claimed to the other carrier. Note other health coverage information in blocks 9 a-d, 6, and 7.

Federal Tax ID Number (block 25)

Enter Physician's Social Security Number (check SSN box) or Tax ID Number. If a Group Practice, enter the Employer Identification Number (EIN)

Total Charge (block 28)

Enter the total amount of the services you are claiming.

Amount Paid (block 29) **REQUIRED**

Enter any co-payment amounts paid to you by the Patient or their responsible party during the period covered by your claim.

Balance Due (block 30)

Enter the amount due to you for this claim. Please note, the actual claim payment is subject to SFMHP Published Rate Schedule, coordination of benefits policies, and the service amount(s) listed on the authorization; and, is limited to the unpaid balance of the Provider's charge.

Signature of Physician or Supplier (block 31) **REQUIRED**

Sign and record the date you are submitting the claim. The signature represents the provider's certification that all information on the document is true and accurate.

Name and Address of Facility where services were rendered, if other than Practitioner's Office. (block 32) **REQUIRED**

Enter the name and address of the facility if the services were furnished in a hospital, clinic, patient's home, or facility other than the physicians' office. If the practitioner's address listed on block 33 and the place of service is the same, please write "SAME".

This block must be completed whether the provider performs the work at the office or at another location.

Provider Billing Information (block 33) **REQUIRED**

Enter the name, address, zip code and telephone number of the practitioner or provider group billing for the service. Enter under "PIN#" your SFMHP Provider ID Number.

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