BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

CMS 1500 Paper Claim Billing Instructions
Form number 0938-1197

Please refer to the National Uniform Claim Committee official 1500 Health Insurance Claim Reference Instruction Manual for definition, field attributes and notes. The manual can be located on the National Uniform Claim Committee website at www.nucc.org.

Please note: if your practice submits claims electronically using a vendor or clearinghouse, you will want to check with them on the fields that require population. They may not have mapped a direct one to one match with the fields defined here.

Below are the BCBSVT/TVHP requirements for the CMS 1500 form. Items highlighted in yellow are the changes for this version.

Definitions:
Required, must be submitted
Optional, field does not require population but if submitted will be accepted
Not Required, cannot be submitted

Item Number	Optional Required Not Required	Special BCBSVT Instructions
1	Required	Check "OTHER" for Blue Cross and Blue Shield of Vermont, The Vermont Health Plan, Federal Employee Program or BlueCard.
1a	Required	Enter the member's identification number exactly as it appears on the identification card, including any alpha prefix (for example ZIA). The alpha prefix or alpha characters in the identification number must be reported as capital letters on paper claims. Note: • BCBSVT Members will have a three-letter alpha, a "V", then 9 digits – the first one starting with a 8 and then three zeros. • Federal Employee Members will have a "R" alpha prefix
2	Required	Patient name cannot contain any special characters.
3	Required	
4	Required	
5	Required	Patients address cannot contain any special characters.
6	Required	
7	Required	
9	Required	Only required if applicable.

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		Please note: if you have marked a "YES" in 11d, this field is required.
9a	Required	Only required if applicable. **Please note**: 1. If you have marked a "YES" in 11d, this field is required. 2. BCBSVT is in the process of moving from Account Numbers to Group Numbers for employer groups. Refer to the information below for further details During this transition, you may find that the Group Number listed on a member's identification card is not the same number that appears during a on line eligibility look up or a HIPAA compliant 270/271 transaction. When billing BCBSVT, you can report either number. BCBSVT does not use this information when validating the member's coverage or eligibility for claim processing. We anticipate the issue will be corrected in mid-2017.
9d	Required	**Please note:** if you have marked a "YES" in 11d, this field is required.
10 a – c	Required	
10d	Not Required	
11	Required	Only required if applicable. Not required for FEP claims, but if submitted will be accepted.
11a	Optional	
11c	Optional	
11d	Required	If marked "YES", complete 9, 9a and 9d. If Medicare is the primary insurer X the "NO."
12	Optional	
13	Optional	
14	Required	
15	Required	Not required for FEP claims, but if submitted will be accepted.
16	Optional	
17	Required/Optional	Required for claims billed by independent laboratories, for all other optional. However, if a referring provider's national provider identifier is present on the claim, you will need to report an appropriate qualifier, or we will deny the claim, asking for a resubmission with the information.
17 a	Optional	
17 b	Optional or Required	National Provider Identifier (NPI) of referring provider is required for all* claims if services are for: • Independent Clinical Lab

<table>
<tr><td></td><td>depending on program</td><td>• Durable Medical Equipment**
• Specialty Pharmacy
*FEP does not require on any claim
** if a member has self-referred you must use your billing DME NPI number</td></tr>
<tr><td>18</td><td>Optional</td><td></td></tr>
<tr><td>19</td><td>Required</td><td>For Medicare Advantage members, height and weight must be populated in this field.</td></tr>
<tr><td>20</td><td>Optional</td><td></td></tr>
<tr><td>21</td><td>Required</td><td>Based on date of service:
○ If prior to October 1, 2015: code with ICD-9*
○ If on/after October 1, 2015 code with ICD-10

*If the ICD-9-CM code being used has a fifth-digit sub-classification, it must be taken out to the fifth digit, even if the fifth digit is a zero.

Please note: claims can’t contain both ICD-9 and ICD-10 codes. If the services provided span the October 1, 2015 ICD-10 implementation date, you’ll need to submit two claims. One claim should contain dates of services up to and including September 30, 2015, with ICD-9 codes. The second claim should contain the services provided on or after October 1, 2015, with ICD-10 codes.</td></tr>
<tr><td>22</td><td>Optional</td><td></td></tr>
<tr><td>23</td><td>Required</td><td>Required.
If you are an ambulance provider, populate with the 5-digit zip code of the point of pickup.</td></tr>
<tr><td>24a</td><td>Required</td><td>Shaded area of 24a:
NDC reporting for home infusion therapy or drugs dispensed or administered by a provider (other than pharmacy). See section 6 of the on-line provider manual for specific details on what requires the billing of NDC.

In the shaded area (above dates of service), report in order: N4 product ID qualifier, 11 digit NDC (no hyphens), unit of measure and quantity (limited to 8 digits before the decimal point and 3 digits after the decimal point). If your software does not allow for automated population in this item number, we will accept the information if hand-written in this area.

Acceptable values for the NDC Units of Measurement Qualifiers are as follows:

<table>
<tr><th>Unit of Measure</th><th>Description</th></tr>
<tr><td>F2</td><td>International Unit</td></tr>
</table>
</td></tr>
</table>

		<table><tr><td>GR</td><td>Gram</td></tr><tr><td>ME</td><td>Milligram</td></tr><tr><td>ML</td><td>Milliliter</td></tr><tr><td>UN</td><td>Unit</td></tr></table> For item number 24d continue to report applicable CPT or HCPCS code. In item number G (days or units) continue to report applicable CPT or HCPCS units and not the NDC units. Non Shaded area of 24a: Indicate the complete numeric date of service for each service performed. Example: 08/01/12. Inclusive dates may be used for identical hospital visits (same as procedure code), for consecutive dates of service only, and must be billed on the same billing line. Example: From 08/01/12 to 08/10/12. Durable Medical Equipment rentals require From and To dates and the dates cannot exceed the date of billing.
24b	Required	BCBSVT requires the use of the two digit place of service codes assigned by Medicare. Special instructions below: **Durable Medical Equipment Suppliers**: if place of service is home item number 5 or 7 (whichever is applicable) and 32 or 33 (whichever is applicable) are required. **Services provided in a school setting**: **03** - used to identify services in a school setting or school owned infirmary for services the provider has contracted directly with the school to provide. **11** – used for office setting or services provided in a school setting or school owned infirmary when the provider is not contracted with the school to provide the services.
24d	Required	Note: if you are reporting the NDC information in item number 24a, For item number 24d continue to report applicable CPT or HCPCS code. In item number G (days or units) continue to report applicable CPT or HCPCS units and not the NDC units.
24e	Required	
24f	Required	
24g	Required	At a minimum, the unit value needs to be populated with a 1. **ANESTHESIA REPORTING**: Paper claims for anesthesia services for BCBSVT, FEP or BlueCard members are only be accepted in minutes. Use item number 24

		g to report the amount of minutes. For example, if you are billing for 15 minutes of anesthesia, report 15 in 24g. Full details and examples are available in Section 6 of our on line provider handbook.
24 h – i	Not Required	
24j	Required	Shaded area of 24j: If you are a provider who has multiple licensures and has been credentialed and contracted by BCBSVT for both specialties or provide specialty services, you must submit separate claim form with a separate taxonomy code in this field*. Examples are, but not limited to: Chiropractor who is also a Physical Therapist or Acupuncturist; Psychiatrist who also does Neuropsych; Naturopath who also does Acupuncture *If you are a provider with multiple specialties, a separate claim must be submitted for each specialty type, they cannot be combined into one claim form for billing purposes. Note: if you submit a taxonomy in this field and it is not required, it will be edited against, which could result in a denial. See Section 1.7 of our on-line Provider Handbook for full details. If you are a physical or occupational therapy assistant, your services have to be submitted under your supervising therapist NPI. You cannot submit under your own NPI. Non shaded area of 24j: This field must contain the complete rendering provider NPI. Please note: if the services rendered do not require a performing provider, populate this field with the billing provider number. Examples of these types of providers would include but are not limited to: durable medical equipment suppliers, laboratories, infusion therapy and ambulance. You will need to indicate your group taxonomy in 33b. **Only one provider (performing a service) per claim can be submitted.**
25	Required	
26	Required	If your practice does not utilize patient account numbers, the field must still be populated using a zero (0). Please note: Patient Account Number should not contain any special characters or spaces. If they do, when reported back to the provider voucher, they will be ignored and only report the alpha or numeric.

27	Required	This field is only required if the claim is being submitted for a member with a Medicare gap type program (such as MedAdvantage) or with a supplemental policy after Medicare. The accept assignment indicates that the provider agrees to accept assignment under Medicare.
28	Required	
29	Required	Only required if applicable.
30	Required	Only required if applicable.
31	Optional	
32	Optional	Only required if different from billing provider located in Item Number 33.
32 a-b	Optional	
33	Required	
33a	Required	
33b	Optional	Only required if the services rendered do not have a performing provider. Examples of this would include but are not limited to durable medical equipment suppliers or ambulance.