Iowa Medicaid
Iowa HHS

# Iowa Medicaid Fee-for-Service

## CMS-1500 Claim Form Instructions

The instructions below provide guidance for submitting a CMS-1500 medical claim and are specific to Iowa Medicaid Fee-for-Service claims.

Effective August 1, 2019, Iowa Medicaid implemented a mandatory electronic billing requirement for all Medicaid enrolled providers. This requirement excludes Individual Consumer Directed Attendant Care (CDAC) providers.

Providers must use these instructions to ensure their system is setup to properly translate these paper claim submission guidelines into the electronic equivalent.

For questions regarding these instructions, please contact Iowa Medicaid Provider Services Monday through Friday 8am-5pm toll free 800-338-7909 or locally at 515-256-4609.

| Field No. | Field Name/ Description | Required or Conditional | Instructions |
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| 1 | Check One | **REQUIRED** | • Checkmark the 'Medicaid' box. |
| 1a | Insured's I.D. Number | **REQUIRED** | • Enter the member's Medicaid ID number.<br>  ○ The Iowa Medicaid ID number consists of seven digits followed by a letter. (I.E. 1234567A).<br>  ○ Medicaid ID numbers are unique to each member.<br>• For instructions on verifying member eligibility, visit: Eligibility and Verification Information System (ELVS) \| Health & Human Services (iowa.gov) |
| 2 | Patient's Name | **REQUIRED** | • Enter the last name, first name, and middle initial of the Medicaid member. |
| 3 | Patient's Birth Date | Not Required | • Enter the date of birth and sex of the Medicaid member.<br>• Enter the member's date of birth in MM/DD/YY format. |
| 4 | Insured's Name | Not Required | • Enter the last name, first name, and middle initial of the Medicaid member. |

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| 5 | Patient's Address | Not Required | • Enter the Medicaid member's home address and phone number, if available. |
| 6 | Patient Relationship to Insured | Not Required | • Checkmark the 'Self' box. |
| 7 | Insured's Address | Not Required | • Enter the Medicaid member's home address, if available. |
| 8 | Reserved for NUCC Use | *CONDITIONAL* | • If you are billing with unlisted CPT/ HCPCS codes; please clearly identify those by listing a description of the item or service. |
| 9 | Other Insured's Name | *CONDITIONAL* | • **REQUIRED IF** the Medicaid member is covered under an additional insurance.<br>○ Enter the policy holder's name of the additional insurance. |
| 9a | Other Insured's Policy or Group Number | *CONDITIONAL* | • **REQUIRED IF** the Medicaid member is covered under an additional insurance. If 11d is marked 'Yes', this field must be completed.<br>○ Enter the policy ID number or group number of the additional insurance. |
| 9b-c | Reserved for NUCC Use | **LEAVE BLANK** | • This field must be left blank. |
| 9d | Insurance Plan Name or Program Name | *CONDITIONAL* | • **REQUIRED IF** the Medicaid member is covered under an additional insurance. If 11d is marked 'Yes', this field must be completed.<br>○ Enter the name of the insurance plan or program. |
| 10 | Is Patient's Condition Related To: | | • **REQUIRED IF** known.<br>○ Enter a 'Yes' or 'No' for each category/line (a, b, and c).<br>○ DO NOT enter 'Yes' and 'No' in the same category/line for this field.<br>○ Auto accidents: Fill in the state abbreviation for location of the accident. |
| 10a | Employment? | *CONDITIONAL* | |
| 10b | Auto Accident? | | |
| 10c | Other Accident? | | |

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| 10d | Claim Codes (Designated by NUCC) | Not Required | • No Entry Required. |
| 11 | Insured's Policy Group or FECA Number | Not Required | • No Entry Required. |
| 11a | Insured's Date of Birth and Gender | Not Required | • Enter the member's date of birth in MM/DD/YY format.<br>• Select appropriate gender box. |
| 11b | Other Claim ID (Designated by NUCC) | Not Required | • No Entry Required. |
| 11c | Insurance Plan Name or Program Name | Not Required | • No Entry Required. |
| 11d | Is There Another Health Benefit Plan? | **REQUIRED** | • If the Medicaid member does **NOT** have additional insurance:<br>  ○ Check 'NO'.<br>• If the Medicaid member does have additional insurance:<br>  ○ Check 'YES.'<br>  ○ Enter the payment amount in field 29.<br>  ○ Ensure boxes 9a-9d are completed.<br>• If the Medicaid member has additional insurance but the benefits were denied:<br>  ○ Check both 'YES' and 'NO.'<br>  ○ Proof of denials must be included in the patient record.<br>• To obtain this information, you may:<br>  ○ Request information from the member.<br>  ○ Verify member eligibility. For instructions, visit: Eligibility and Verification Information System (ELVS) \| Health & Human Services (iowa.gov)<br>• Auditing will be performed on a random basis to ensure correct billing. |

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| 12 | Patient's or Authorized Person's Signature | Not Required | • No entry required. |
| 13 | Insured or Authorized Person's Signature | Not Required | • No entry required. |
| 14 | Date of Onset or Pregnancy (LMP) and Qualifier | *CONDITIONAL* | • **REQUIRED** for Chiropractors.<br>○ For pregnancy, use the date of the Last Menstrual Period (LMP) (Qualifier 484 must be used).<br>○ For non-pregnancy, use the date of onset of current symptoms or illness (Qualifier 431 must be used). |
| 15 | Other Date and Qualifier | *CONDITIONAL* | • **REQUIRED** for Chiropractors.<br>○ Chiropractors must enter the date of the most recent x-ray (Qualifier 455 must be used).<br>○ Entry must be made in MM/DD/YY format. |
| 16 | Dates Patient Unable to Work in Current | Not Required | • No entry required. |
| 17 | Name of Referring Provider or Other Source | *CONDITIONAL* | • Enter the name of the referring physician or professional.<br>• If services are provided to an individual based on a referral from an Indian Health Services (IHS) provider, enter the name of the IHS clinic who made the referral.<br>• Entry must be entered in the format of 'first name, middle initial, last name, and credentials.' |
| 17a | | Not Required | • This field must be left blank. |

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| 17b | NPI | *CONDITIONAL* | • **REQUIRED IF** Box 17 was filled out.<br>  ○ Enter the NPI of the referring physician or professional.<br>  ○ If services are provided to an individual based on a referral from an Indian Health Services (IHS) provider, enter the NPI of the IHS facility making the referral. Do not use the NPI of the individual provider. |
| 18 | Hospitalization Dates Related to Current Services | Not Required | • No entry required. |
| 19 | Additional Claim Information (Designated by NUCC) | *CONDITIONAL* | • Enter the NPI number of the referring or prescribing provider.<br>• If this claim is for consultation, independent labs, or DME, enter the NPI of the referring or prescribing provider. |
| 20 | Outside Lab | Not Required | • No entry required. |
| 21 | Diagnosis or Nature of Illness or Injury and ICD Indicator | **REQUIRED** | • Indicate the applicable ICD-CM diagnosis codes in order of importance (A-primary; B- secondary; C-tertiary; D-quaternary) to a maximum of twelve diagnoses.<br>• If the patient is pregnant, one of the diagnosis codes **must** indicate pregnancy. The pregnancy diagnosis codes are as follows:<br>  ○ **ICD-10-CM:** Any diagnosis code to indicate pregnancy. EX: Z33.1<br>• Indicate a 0 for the ICD Indicator when submitting ICD- 10-CM.<br>• **DO NOT** enter descriptions. |
| 22 | Resubmission Code | Not Required | • No entry required. |

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| 23 | Prior Authorization Number | *CONDITIONAL* | • **REQUIRED IF** there is a prior authorization.<br>  ○ Obtain the prior authorization number from the prior authorization form and enter in this field.<br>• **REQUIRED** for Independent Laboratories<br>  ○ Enter CLIA Certification number in this field.<br>• If both criteria above apply, enter the CLIA certification number instead of the prior authorization number. |
| 24<br>Top Shaded Portion | Date(s) of Service/NDC | *CONDITIONAL* | • **REQUIRED** for physician-administered drugs.<br>  ○ Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs).<br>• Do not use spaces or symbols in this field. |
| 24A<br>Lower Portion<br><br><br><br><br><br><br><br>24B<br>Lower Portion | Date(s) of Service<br><br><br><br><br><br><br><br>Place of Service | **REQUIRED**<br><br><br><br><br><br><br><br>**REQUIRED** | • Enter the month, day, and year under both the 'From' and 'To' categories for each procedure, service, or supply.<br>• Entry should be made in MM/DD/YY format.<br>  • Using the list below, enter the number that corresponds to the claim's place of service.<br>  • **DO NOT** use alphabetic characters.<br>**02** – Telehealth<br>**03** – School<br>**04** – Homeless Shelter<br>**06** – Indian Health Service Provider-Based Facility<br>**07** – Tribal 638 Free-standing Facility<br>**08** – Tribal 638 Provider-based Facility<br>**10** – Telehealth in patient home |

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| | | | **11** – Office<br>**12** – Patient's Home<br>**13** – Assisted Living Facility<br>**14** – Group Home<br>**15** – Mobile Unit<br>**16** – Temporary Lodging<br>**17** – Walk-in Retail Health Clinic<br>**19** – Off Campus Outpatient Hospital<br>**20** – Urgent Care Facility<br>**21** – Inpatient Hospital<br>**22** – On Campus Outpatient Hospital<br>**23** – Emergency Room Hospital<br>**24** – Ambulatory Surgical Center<br>**25** – Birthing Center<br>**27** – Outreach Street<br>**31** – Skilled Nursing Facility<br>**32** – Nursing Home<br>**33** – Custodial Care Facility<br>**34** – Hospice<br>**41** – Ambulance (Land)<br>**42** – Ambulance – Air or Water<br>**49** – Independent Clinic<br>**50** – FQHC (Federally Qualified Health Center)<br>**51** – Inpatient Psychiatric Facility<br>**52** – Psychiatric Facility – Partial Hospitalization<br>**53** – Daycare Facility Psych<br>**54** – Intermediate Care Facility (ID)<br>**55** – Residential Substance Abuse Treatment Facility<br>**56** – Psychiatric Residential Treatment Center<br>**57** – Non-Residential Substance Abuse Treatment Facility |

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| | | | **58** – Non-Residential Opioid Treatment Facility<br>**60** – Mass Immunization Center<br>**61** – Comprehensive Inpatient Rehab<br>**62** – Comprehensive Outpatient Rehab<br>**65** – End Stage Renal Disease Treatment<br>**71** – State or Local Public Health Clinic<br>**72** – Rural Health Clinic<br>**81** – Independent Lab<br>**99** – Other Unlisted Facility |
| 24C<br>Lower Portion | EMG | Not Required | • No entry required. |
| 24D<br>Lower Portion | Procedures, Services, or Supplies | **REQUIRED** | • Enter a code for each date of service.<br>• If no fees were charged, DO NOT list the service(s).<br>• Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) or valid Current Procedural Terminology (CPT).<br>  ○ DO NOT enter the description.<br>• When applicable, show HCPCS code modifiers with the HCPCS code.<br>• **FQHC/RHC**-<br>  ○ Bill the encounter code T1015 on the first claim line.<br>  ○ Bill applicable specific procedure code(s) on subsequent claim claims with $0.00 charge as 'informational only.'<br>  ○ Claims submitted without 'informational only' procedure codes will be denied. |

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| 24E<br>Lower Portion | Diagnosis Pointer | **REQUIRED** | • Indicate the corresponding diagnosis code from field 21 by entering the letter of its position (i.e., C.)<br>• DO NOT enter the actual diagnosis code in this field (This will cause a denial).<br>• Each line allows a maximum of four diagnosis code pointers. |
| 24F<br>Lower Portion | $ Charges | **REQUIRED** | • Enter the usual and customary charge for each line item billed.<br>• The charge must include both dollars and cents. |
| 24G<br>Lower Portion | Days or Units | **REQUIRED** | • Enter the number of times this procedure was performed, or number of supply items dispensed. If the procedure code specifies the number of units, then enter '1.'<br>• General Anesthesia: The units of service must reflect the total minutes of general anesthesia. |
| 24H<br>Lower Portion | EPSDT/<br>Family Planning | *CONDITIONAL* | • **REQUIRED IF** services are a result of Family Planning or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Care for Kids Screening.<br>○ Enter 'Y' on this claim line.<br>• If neither of the above scenarios apply, enter 'N.' |
| 24I<br>Top Shaded | ID. Qual. | Not Required | • This field must be left blank. |
| 24J<br>*TOP SHADED* | Rendering Provider ID. # | Not Required | • This field must be left blank. |
| 24J<br>*LOWER PORTION* | NPI | **REQUIRED** | • Enter the NPI of the individual provider who rendered (performed) the service(s).<br>• **FQHC/RHC**- Enter the clinic NPI number or leave blank. |
| 25 | Federal Tax I.D. Number | Not Required | • No entry required. |

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| 26 | Patient's Account No. | Not Required | • Enter the patient's account number assigned by the servicing provider.<br>• This field is limited to 13 alpha/numeric characters. |
| 27 | Accept Assignment? | Not Required | • No entry required. |
| 28 | Total Charge | **REQUIRED** | • Enter the total line-item charges on the LAST page of the claim.<br>• If more than one claim form is used to bill for services, the claim total charge should only be provided on the last page.<br>• Prior to the last page, all other pages must have box 28 completed with the word 'continued' or 'page 1 of <Enter total # of pages>.' |
| 29 | Amount Paid | *CONDITIONAL* | • **REQUIRED IF** the member has additional insurance, **and** the insurance has made a payment on the claim.<br>○ Enter only the amount paid by the other insurance. Member copayments, Medicare payments or previous Medicaid payments should not be listed on this claim.<br>○ Do not submit this claim until you receive a payment or denial from the other insurance carrier.<br>○ Proof of denials must be included in the patient record.<br>○ If more than one claim form is used to bill services performed and a prior payment was made, the third-party payment should be entered on ***each page*** of the claim in Box 29. |
| 30 | Reserved for NUCC/Local Use | Not Required | • This field must be left blank. |

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| 31 | Signature of Physician or Supplier | **REQUIRED** | • Enter the signature of either the physician or authorized representative and the original filing date.<br>• If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.<br>• The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of the claim form. |
| 32 | Service Facility Location Information | Not Required | • Enter the complete address of the service facility.<br>• The address must be a physical location and cannot be a P.O. Box. |
| 32a | NPI | Not Required | • Enter the NPI of the facility where service(s) were rendered. |
| 32b | Untitled | Not Required | • This field must be left blank. |
| 33 | Billing Provider Info & Phone # | **REQUIRED** | • Enter the complete name and address of the billing provider.<br>○ The address provided must contain the full zip code (Zip+4) in the format of 5 digits – 4 digits.<br>○ The zip code entered must match the zip code on file with Iowa Medicaid. A mismatch will cause a denial.<br>○ To verify the zip code on file with Iowa Medicaid, please contact Provider Services (Page 1). |
| 33a | NPI | **REQUIRED** | • Enter the billing provider's NPI (Pay-to-Provider).<br>• **FQHC/RHC:** Enter the clinic's NPI. |

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| 33b | Untitled | **REQUIRED** | • Enter the billing provider's taxonomy code associated with the service(s) provided.<br>• A "**ZZ**" qualifier must precede the taxonomy code.<br>• The taxonomy code entered must match the taxonomy code on file with Iowa Medicaid. A mismatch will cause a denial.<br>• To verify the taxonomy code on file with Iowa Medicaid, please contact Provider Services (Page 1). |