HealthPlan OF SAN MATEO
Healthy is for everyone

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Required Data Items for CMS 1500

The following item numbers and descriptions correspond to the standard CMS 1500 Claim Form. Both paper and electronic claims require the same data elements, which are based on Medi-Cal procedures. Claims may be pended or denied when data items are incomplete or incorrect.

Note: Items described as "Not Required by HPSM" may be completed for other payers but are not recognized by the HPSM claims processing system.

Health Plan of San Mateo HCFA 1500 Submission Requirements

Field Number	Description	Requirement
1	Medicaid/Medicare/Other ID	Enter an "X" in the Medicaid Box
1A	Insured's ID	Enter Patient 9 Digit HPSM ID Number
2	Patient's Name	Required
3	Patient's Birth date/Sex	Enter the Recipient's Date of Birth in Six-Digit Format (MMDDYY)
4	Insured's Name	"Not Required by HPSM"
5	Patient's Address/Telephone	Enter Recipients Complete Address and Telephone Number
6	Patient Relationship to Insured	This Field May Be Used When Billing for an Infant Using the Mother's ID by Checking the Child Box
7	Insured's Address	"Not Required by HPSM"
8	Patient Status	"Not Required by HPSM"
9	Other Insured's Name	"Not Required by HPSM"

9A	Other Insured's Policy or Group Number	"Not Required by HPSM"
9B	Other Insured's Policy or Group Number	"Not Required by HPSM"
9C	Employer's Name or School Name	"Not Required by HPSM"
9D	Insurance Plan Name or Program Name	"Not Required by HPSM"
10	Is Patient's Condition Related To:	"Not Required by HPSM"
10A	Employment	"Not Required by HPSM"
10B	Auto Accident/Place	"Not Required by HPSM"
10C	Other Accident	"Not Required by HPSM"
10D	Reserved for Local Use	Enter the amount of patient's Share-of-Cost for the procedure, service or supply. Do not enter a decimal point (.) Or dollar sign ($). (e.g. if billing for $100, enter 10000 not 100)
11	Insured's Policy Group or FECA Number	"Not Required by HPSM"
11A	Insured's Date of Birth/Sex	"Not Required by HPSM"
11B	Employer's Name or School Name	"Not Required by HPSM"
11C	Insurance Plan Name of Program Name	"Not Required by HPSM"
11D	Is There Another Health Benefit Plan?	Enter an "X" in the box if the recipient has other coverage.
12	Patient's or Authorized Person's Signature	"Not Required by HPSM"
13	Insured's or Authorized Person's Signature	"Not Required by HPSM"

14	Date of Current Illness, Injury or Pregnancy	"Not Required by HPSM"
15	Similar Illness	"Not Required by HPSM"
16	Date Unable to Work	"Not Required by HPSM"
17	Referring Provider	"Not Required by HPSM"
17A	ID Number of Referring Physician	Enter the referring/prescribing/ ordering practitioner's Medi-Cal provider # or if not a Medi-Cal provider enter State license number. If license number is used the full name of the practitioner must be entered in box 17
18	Hospitalization Dates	Enter dates of admission and discharge
19	Reserved for Local Use	Use this area for procedures that require additional information, justification or and Emergency Certification Statement. See Medi-Cal Medical Services Manual 300-31-9 for additional information.
20	Outside Lab	Name is modifier 90 of Lab
21.1	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers for the primary diagnosis, use an ICD-9-CM code number and code to the highest level of specificity for the date of service. (Do not enter decimal point.)
21.2	Diagnosis or Nature of secondary Illness or Injury	Enter all letters and/or numbers for the secondary diagnosis, use an ICD-9-CM code number and code to the highest level of specificity for the date of service. (Do not enter decimal point.)

21.3	Diagnosis or Nature of tertiary Illness or Injury	Enter all letters and/or numbers for the tertiary diagnosis, use an ICD-9-CM code number and code to the highest level of specificity for the date of service. (Do not enter decimal point.)
21.4	Diagnosis or Nature of quartern Illness or Injury	Enter all letters and/or numbers for the quartern diagnosis, use an ICD-9-CM code number and code to the highest level of specificity for the date of service. (Do Not enter decimal point.)
22	Medicaid Re-submission Code	"Not Required by HPSM"
23	Prior Authorization Number	For physician and pediatric services requiring a Treatment Authorization Request (TAR), enter the 11-digit TAR control number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Only one TAR Control Number can cover the services billed on any one claim
24. A.	Date(s) of Service	Enter the date the service was rendered in the "From" and "To" boxes in the six-digit MMDDYY, format
24. B.	Place of Service	Enter code indicating were service was rendered (e.g 11= office, 21-Inpatient Hospital, etc.)
24. C.	EMG	Leave this box blank unless billing for emergency services. Enter and "X" if an Emergency Certification Statement is attached to this claim or enter in Box 19

24D	Procedures, Services, or Supplies Modifier	Enter the applicable procedure code (HCPCS or CPT-4 and modifier)
24E	Diagnosis Code	Indicate which ICD-9 code in 21 (1, 2, 3, & 4) is applicable to the service
24F	Charges	In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign ($). If an item is a taxable medical supply, include the applicable state and county sales tax
24G	Days or Units	Enter the number of medical 'visits", surgical "lesions", hours of "detention time", units of anesthesia time, etc.
24H	EPSDT Family Plan	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are CHDP-screening related. Leave blank if not applicable
24I	ID Qual	"Not Required by HPSM"
24J	Rendering Provider ID. #	Enter the rendering providers NPI and/or Legacy #
25	Federal Tax ID Number	Enter the nine digit provider Tax ID number
26	Patient's Account No.	This is an optional field that will help you to easily identify a recipient on RTDs and EOBs.
28	Total Charge	In full dollar amount, enter the total for all services. Do not enter a decimal point (.) Or dollar sign ($).
29	Amount Paid	Enter the amount of payment received from the other coverage

		(box10D). Do Not enter Medicare payments in this box. Medicare payment amount will be calculated from the Medicare EOMB/RA when submitted with the claim.
30	Balance Due	Enter the difference between Total Charges and Amount Paid
31	Provider Signature/Date	“Not Required by HPSM”
32	Service Facility Location	Enter the name and address where services were rendered
32 a	NPI of the Service Facility Location	Enter the NPI of the facility identified in 32 if applicable
32 b	Legacy # of the Service Facility Location	Enter the Legacy number of the facility identified in 32 if applicable
33	Billing Provider Info & Ph #	Enter the name, address and telephone number of the billing provider
33 a	Billing Provider NPI	Enter the NPI of the billing provider if applicable
33 b	Billing Provider Legacy #	Enter the Legacy number of the billing provider if applicable