An independent licensee of the Blue Cross and Blue Shield Association

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Provider Highlights

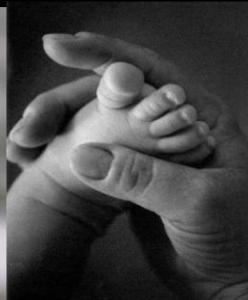
1500 Form Required Fields

The following table explains the various REQUIRED fields of the paper CMS-1500 form. The numbers correspond to those on the CMS-1500 02/12 claim form. Supplemental and voluntary information fields are labeled NOT REQUIRED.

In addition to completing the required fields, be sure to format your paper claims according to the Tips for Submitting OCR claims guideline located on our Provider News page. Required fields on an electronic claim may vary. Consult with your vendor or EDISS to confirm required fields for electronic transactions.

Field No.	Field Name	Explanation
1a	Insured's ID Number	Enter the member's BCBS number as it appears on the identification card.
2	Patient's Name	Enter the patient's name.
3	Patient's Birth Date and Sex	Indicate the month, day and year of birth and check the appropriate box.
4	Insured's Name	Enter the member's name as it appears on the identification card.
5	Patient's Address	NOT REQUIRED
6	Patient Relationship to Insured	Check the appropriate box for relationship of patient to the member.
7	Insured's Address	NOT REQUIRED
8	Reserved for NUCC Use	NOT REQUIRED
9	Other Insured's Name	NOT REQUIRED
10	Is Patient's Condition Related to:	Check the appropriate box if the member's condition is related to employment or an auto accident, or check "other" if appropriate.
11	Insured's Policy Group or FECA Number	NOT REQUIRED
12	Patient's or Authorized Person's Signature	NOT REQUIRED
13	Insured's or Authorized Person's Signature	NOT REQUIRED
14	Date of Current Illness/Injury/or Pregnancy	Enter the date (month, day, year) the member became injured. Required for primary diagnosis in the 800-999 range.
15	Other Date	If an Accident Date needs to be reported, enter the date along with qualifier "439".
16	Dates Patient Unable to Work in Current Occupation	NOT REQUIRED
17	Name of Referring Physician or Other Source	NOT REQUIRED
17a	Blank	NOT REQUIRED
17b	NPI	Enter the National Provider Identifier (NPI) number of the referring, ordering or supervising provider.

(continued)



Field No.	Field Name	Explanation
18	Hospitalization Dates Related to Current Services	NOT REQUIRED
19	Additional Claim Information	NOT REQUIRED
20	Outside Lab	NOT REQUIRED
21	Diagnosis or nature of illness or injury which relates to the service line below (24E)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Specify the ICD codes. Should include no more than twelve diagnosis codes as indicated on the form. Enter up to twelve diagnosis codes in order of priority using the degree of specificity.
22	Resubmission Code	NOT REQUIRED
23	Prior Authorization Number	NOT REQUIRED: Leave blank, or if applicable enter the prior authorization number given to you.
24a	Date of Service	Enter the month, day and year for each service. If you are providing the same level or medical care for consecutive dates, include the from/to dates.
24b	Place of Service	Enter the appropriate place of service code.
24c	EMG (emergency)	NOT REQUIRED
24d	Procedures, Services or Supplies	Describe the services rendered using current CPT, HCPCS or ASA procedure codes. Attach reports when billing unlisted procedure codes.
24e	Diagnosis Pointer	Enter the appropriate letter identifier that corresponds to the appropriate diagnosis for the service performed.
24f	Charges	Enter the charge for the service performed.
24g	Days or Units	Enter the number of units for the service provided. Enter in time in minutes as the units for Anesthesia services. For ambulance mileage round to the nearest tenth of a mile.
24h	EPSDT/Family Plan	NOT REQUIRED
24i	ID Qualifier	NOT REQUIRED
24j	Rendering Provider Number	Enter the individual (type 1) NOP or the rendering provider in the bottom portion of 24j.
25	Federal Tax ID Number	Enter the Tax ID number of the billing provider.
26	Patient's Account Number	NOT REQUIRED
27	Accept Assignment	NOT REQUIRED
28	Total Charge	Total charge for the services. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	NOT REQUIRED
30	Reserved for NUCC Use	NOT REQUIRED
31	Signature of Physician	Enter the name of the provider or indicate signature on file.
32	Service Facility Location	Enter the address where the service was rendered.
32a	Service Facility Location Information-NPI	NPI of service facility location. The NPI of the location where services were provided must be included.
33	Billing Provider Info	Enter the name, address and telephone number of the billing provider.
33a	Billing Provider NPI	Enter the organizational (type 2) NPI.