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

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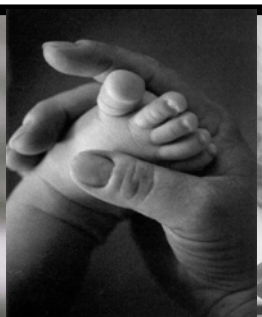
Provider Highlights

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 08/05 claim form. Fields not required by BCBSWY 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. 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 date of birth 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 appropriate box for relationship of patient to the member.
7	Insured's Address	NOT REQUIRED
8	Patient Status	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	Authorized Signature	NOT REQUIRED
14	Date of Current Illness/Injury/Date of Pregnancy	Enter the date (month, day, year) the member became injured. Required for a primary diagnosis in the 800-999 range.
15	If the Patient Has Had the Same or Similar Illness, Give First Date	NOT REQUIRED
16	Date Patient Unable to Work in Current Occupation	NOT REQUIRED
17	Name of Referring Physician or Other Source	NOT REQUIRED
17a	ID Number of Referring Physician	NOT REQUIRED
18	Hospitalization Dates Related to Current Services	NOT REQUIRED
19	Reserved for Local Use	NOT REQUIRED
20	Outside Lab?	NOT REQUIRED

(Continued)


1500 Form Required Fields (continued)

21	Diagnosis or Nature of Illness or Injury	Specify the ICD-9 codes.
22	Medicaid Reimbursement Code	NOT REQUIRED
23	Prior Authorization Number	NOT REQUIRED: Leave blank, or if applicable enter the prior authorization number given to you.
24	Supplemental Information	NOT REQUIRED: Leave blank or use the shaded portion of line 24 to indicate supplemental information such as the start and stop times for anesthesia, National Drug Codes (NDC) for drugs, or narrative description of unspecified codes.
24a	Date of Service	Enter the month, day, and year for each service. If you are providing the same level of medical care for consecutive dates, include the from/to dates.
24b	Place of Service Code	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 number 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.
24j	Rendering Provider Number	Enter the individual (type 1) NPI of the rendering provider in the bottom portion of 24j.
25	Federal Tax ID Number	Enter the Tax ID number of the billing provider.
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.
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.