CCA - Claims Requirements 1500 Professional Form

Field #	Field Name	Instruction	Formatting Requirement	Description
1	Carrier Type	Optional		Type of Insurance
1a	Insured's ID Number	Required		Insured's CCA ID Number - Enter the member's CCA number as it appears on the ID card.
2	Patient's Name	Required		Enter the member's name as is indicated on the ID card.
3	Patient's Date of Birth/Sex	Required	MMDDYYYY F or M or U	Patient's Birth date - Enter member's date of birth and check the box for male or female or unassigned.
4	Insured's Name (Leave blank if Medicare is primary)	Required		Insured's Name - Not required unless billing for an infant using the Mother's ID.
5	Patient's Address	Required		Patient's Address - Enter member's complete address and telephone number.
6	Patient's Relationship to Insured	Required		Patient's Relationship to Insured - Only Self or Child are applicable.
7	Insured Address	Optional		Insured Address
8	Reserved	DO NOT USE		
9	Other Insured's Name	Required (if box 11d is Yes)		Other Insured's Information Name
9a	Other Insured's Policy or Group Number	Required (if box 11d is Yes)		Other Insured's Information Policy/Group Number
9b	Reserved	DO NOT USE		
9c	Reserved	DO NOT USE		
9d	Insurance Plan Name or Program Name if Applicable	Required (if box 11d is Yes)		Other Insured's Information Employer/School Name, Insurance Plan/Program Name
10	Is Patient's Condition Related to:			
10a	Employment	Required (if applicable)		Check Yes or No
10b	Auto Accident	Required (if applicable)		Check Yes or No
10c	Other Accident	Required (if applicable)		Check Yes or No
10d	Reserved	DO NOT USE		
11	Insured's Policy Group or FECA Number	Required		Insured's Information - Policy/Group Number

		(if applicable)		
11a	Insured's Date of Birth	Required (if applicable)	MMDDYYYY	Insured's Date of Birth
11b	Other Claim ID designated by NUCC	Required (if applicable)		
11c	Insurance Plan Name or Program Name	Required (if applicable)		Insured's Information - Plan/Program Name
11d	Is there Another Health Benefit Plan?	Required		Check Yes or No
12	Patient's or Authorized Person's Signature (Medical Records/Information Release) and Date	Required		Signature and Date
13	Insured's or Authorized Person's Signature (Assignment of Benefits)	Required		Insured's or Authorized Person's Signature
14	Date of Current Illness, Injury, Pregnancy, Qualifier	Optional	MMDDYY or MMDDCCYY	Date of Current - Illness (First Symptom) OR Injury OR Pregnancy (LMP) - Enter the date of onset of the member's illness, the date of accident/injury or the date of the last menstrual period.
15	Qualifier, First Date of Onset of Same/Similar Illness	Optional		If patient had same or similar illness give first date
16	Dates Unable to Work in Current Occupation	Optional	MMDDYY or MMDDCCYY	Dates Patient Unable to Work in Current Occupation
17	Qualifier/Name of Referring Physician	Required (if applicable)		Name of Referring Provider or Other Source - Enter the full name of the Referring Provider. A referring/ordering provider is one who requests services for a member, such as provider consultation, diagnostic laboratory or radiological tests, physical or other therapies, pharmaceuticals or durable medical equipment.
17a	Legacy Referring	Required (if applicable)		ID Number of Referring Physician - Enter State Medical License number.
17b	Referring Physician NPI#	Required (if applicable)	10-digit number	Enter Referring Provider's NPI number.

18	Qualifier/Hospitalization Dates Related to Current Services	Optional	MMDDYY or MMDDCCYY	Hospitalization Dates Related to Current Services - Enter the date of hospital admission and discharge if the services billed are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.
19	Additional Claim Information designated by NUCC	Optional	MMDDYY or MMDDCCYY	Reserved for Local Use - Use this area for procedures that require additional information, justification or an Emergency Certification Statement. • This section may be used for an unlisted procedure code when explanation is required and clinical review is required. • If modifier "-99" multiple modifiers are entered in section 24d, they should be itemized in this section. All applicable modifiers for each line item should be listed. • Claims for "By Report" codes and complicated procedures should be detailed in this section if space permits. • All multiple procedures that could be mistaken for duplicate services performed should be detailed in this section. • Anesthesia start and stop times. • Itemization of miscellaneous supplies, etc.
20	Outside Laboratory?	Optional		Check "yes" when diagnostic test was performed by any entity other that the provider billing the service. If this claim includes charges for laboratory work performed by a licensed laboratory, enter "X." "Outside Laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	9-digit number OR 10-digit AN	Enter all letters and/or numbers of the ICD-10 code for each diagnosis, including fourth and fifth digits if present. The first diagnosis listed in section 21.1 indicates the primary reason for the service provided
22	Resubmission Code:	Required for correction or voiding of a claim only		Enter: 7 for a corrected claim 8 for a voided claim AND Original Reference Code: Enter the Claim ID number of the claim you are requesting to correct or void. Both data elements above are required.
23	Prior Authorization Number	Required (if applicable)		Enter prior authorization or referral number.

24a	Date of Service, From and To	Required	MMDDYY or MMDDYYYY	Enter the date the service was rendered in the “from” and “to” boxes in the MMDDYY format. If services were provided on only one date, they will be indicated only in the “from” column. If the services were provided on multiple dates (i.e., DME rental, hemodialysis management, radiation therapy, etc), the range of dates and number of services should be indicated. “To” date should never be greater than the date the claim is received by the health plan.
24b	Place of Service	Required	2-digit number	Enter two-digit code indicating where the service was rendered.
24c	Emergency Service	Optional		Check box and attach required documentation.
24d	Procedures, Services or Supply Code including modifiers if applicable NDC numbers	Required		Enter the applicable CPT and/or HCPCS National codes in this section. Modifiers, when applicable, are listed to the right of the primary code under the column marked “modifier.” If the item is a medical supply, enter the two-digit manufacturer code in the modifier area after the five-digit medical supply code. ***Reminder***: Payment modifiers should be in first position.
24e	Diagnosis Pointer	Required		Enter the diagnosis code number from box 21 that applies to the procedure code indicated in 24D.
24f	Charges	Required		Enter the charge for service in dollar amount format. If the item is a taxable medical supply, include the applicable state and county sales tax.
24g	Days or Units	Required		Enter the number of medical visits or procedures, units of anesthesia time, oxygen volume, items or units of service, etc. Do not enter a decimal point or leading zeroes. Do not leave blank as units should be at least 1.
24h	EPSDT Family Plan	Optional		Enter code “1” or “2” if the services rendered are related to family planning (FP). Enter code “3” if the services rendered are Child Health and Disability Prevention (CHDP) screening related
24i	ID Qualifier	Optional		Enter “X” if billing for emergency services.
24j	Provider ID Number Taxonomy Rendering Provider NPI Number	Optional Required	10-digit number 10 digit number	Enter the Rendering Provider's NPI number

25	Federal Tax ID Number	Required	9-digit number	Enter the Federal Tax ID for the billing provider.
26	Patient's Account Number	Required	Length 20 max.	Enter the patient's medical record number or account number in this field. This number will be reflected on Explanation of Benefits (EOB) if populated.
27	Accept Assignment	Required		Check Yes or No
28	Total Charge	Required		Enter the total for all services in dollar and cents. Do not include decimals. Do not leave blank.
29	Amount Paid	Required (if applicable)		Enter the amount of payment received from the Other Health Coverage. Enter the full dollar amount and cents. Do not enter Medicare payments in this box. Do not enter decimals.
30	Reserved	DO NOT USE		
31	Signature of Practitioner or Supplier and Date	Required		The claims must be signed and dated by the provider or a representative assigned by the provider in black pen. An original signature is required. Stamps, initials or facsimiles are not acceptable.
32	Service Facility Location/Location where services were rendered	Required		Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.
32a	Service Facility NPI if different from Billing Provider NPI	Required (if applicable)	10-digit number	Enter the NPI of the facility where the services were rendered.
32b	Other ID	Optional		Enter the provider number for an atypical service facility.
33	Billing Provider/Supplier's Name, Address, & Telephone Number as it appears on your W-9	Required		Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number.
33A	Billing Provider/Supplier's NPI Number	Required	10-digit number 10-digit number	Enter the billing provider's NPI.
33b	Other ID	Optional		Used for atypical providers only. Enter the provider number for the billing provider.