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Claims and billing manual

Claims and billing overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members' care more efficiently. With that in mind, Wellpoint has made claims processing as streamlined as possible. Please share the following guidelines with your staff, billing service, and electronic data processing agents:

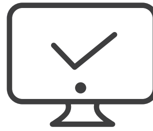
- Submit clean claims, making sure the right information is on the right form.
- Submit claims as soon as possible after providing the service(s).
- Submit claims within the contracted filing time limit.
- Only submit correction claims when there are material changes made to the claim.

You can check claim status at **Availity.com** (Note: you must register with Availity to access the secure portion of the website). Once registered, you can log in to a single account and perform numerous administrative tasks for members covered by Iowa Health Link or by other selected payers. You may also access Availity from our **website** by selecting **Login** or **Register**.

There are two types of forms you will need for reimbursement. These forms are available electronically:

- ***CMS-1500*** for professional services
- ***CMS-1450 (UB-04)*** for institutional services

Submitting clean claims



Claims are defined as clean when they are submitted without any defects, with all required information required for processing and in the timely filing period.

For claims that are not accepted or rejected, an error report is generated and sent to the provider. Some scenarios where a claim may be returned include:

- A claim submitted with incomplete or invalid information (including those submitted through electronic data interchange [EDI]).
- A claim submitted without the proper *HIPAA*-compliant code set.

You and your staff are responsible for working with your clearinghouse to ensure erred out claims are corrected and resubmitted.

Claim filing limits:

- PAR provider: Member does not have primary carrier; 180 days from date of service
- OON (Non-PAR) provider (Member does not have primary carrier); 365 days from date of service
- PAR provider: Member DOES have primary carrier; 365 days from last date of *EOP* from primary carrier
- OON (non-PAR) provider (Member DOES have primary carrier); 365 days from last date of *EOP* from primary carrier
- Corrected Claim — 365 days from last date of *EOP* from Wellpoint — with a MAXIMUM of 2 years from original date of service
- Facility Based- Interim/Continuing Claims; 180 days for PAR — beginning on first date of statement to/from, NON-PAR- 365 days for NON/PAR and OHI — on first date of statement to/from period

Submitting paper claims

Paper claims are not accepted by Wellpoint effective as of October 1, 2019.

Please note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

Electronic remittance advice

Wellpoint providers can choose to receive electronic remittance advices (ERAs). ERAs are received through an electronic mailbox set up between Wellpoint, the provider and/or the provider's clearinghouse. For more information call the EDI solutions help desk at **800-590-5745**.

Client participation/member liability

Some members have a member liability, also referred to as client participation, which must be met before Medicaid reimbursement for services is available. Iowa Health and Human Services (HHS) has the responsibility of determining the member liability amount. This includes a portion of members eligible for Medicaid on the following bases: (i) members in an institutional setting; and (ii) 1915(c) HCBS waiver enrollees.

Through the HHS eligibility and enrollment files, the state will notify Wellpoint of any applicable member liability amounts. This information will be made available to providers. Providers are responsible to collect this amount from the member and bill gross/full charges. We will adjudicate the claim and deduct the patient liability amount. Client participation is withheld from claims as they are received, on a first in first out basis.

In the event the sum of any applicable third-party payment and a member's financial participation equals or exceeds the reimbursement amount established for services, we will make no payment to the provider.

Home- and community-based service (HCBS) claims:

- HCBS claims are only accepted on the electronic version of the *CMS-1500*.
- HCBS waiver claims may be date span billed but may not cross over calendar months.

Consumer-Directed Attendant Care (CDAC) claims

Consistent with state and federal guidelines all CDAC claims (agency and individual) must be submitted through Electronic Visit Verification (EVV) unless there is a clearly documented exception.

Atypical Providers Special Notes

Atypical providers are service providers who do not meet the definition of healthcare provider. Atypical providers are required to use the state assigned atypical NPI number given to them by the state of Iowa to take the place of the NPI. Atypical providers are not always assigned an NPI number, however, if an atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider.

Coordination of benefits/third party liability:

- Wellpoint, like all Medicaid payers, is the payer of last resort.
- For members who have primary other carriers, Wellpoint will coordinate claims in alignment with state guidelines.
- Wellpoint will not render Medicaid payment, where the provider or member has not followed the primary carriers, rules including untimely filing, failure to prior authorize, or duplication of claims.
- Wellpoint participates in coordination of benefits agreement (COBA) to adjudicate claims received directly from CMS, for our members who carry Medicare coverage. Most claims will automatically crossover in this process, so providers should use caution in submitting crossover claims manually to Wellpoint. If the COBA claims require correction, please carefully follow all correction claim guidelines to avoid duplication.
- In instances where the primary carrier does not cover a service and service is otherwise Medicaid covered, and in turn Wellpoint will function as the primary carrier, all standard guidelines including prior authorization will be enforced.

Corrected claims:

- Please refer to Wellpoint's provider website within the reimbursement Policies for the full policy on corrected claims
- Corrected claims shall only be submitted when there are material changes required to the data previously submitted with a clerical error or required retroactive update. If a claim requires adjustment that is not a material change to the claim information, providers shall use the claims payment reconsideration or appeal processes.
- Wellpoint requires that a corrected claim be submitted for each member and encounter. Corrected claims are not accepted in bulk, batch, or packaged fashion.
- Failure to bill the required frequency indicating a correction or identifying the prior identified claim ID will result in denials.

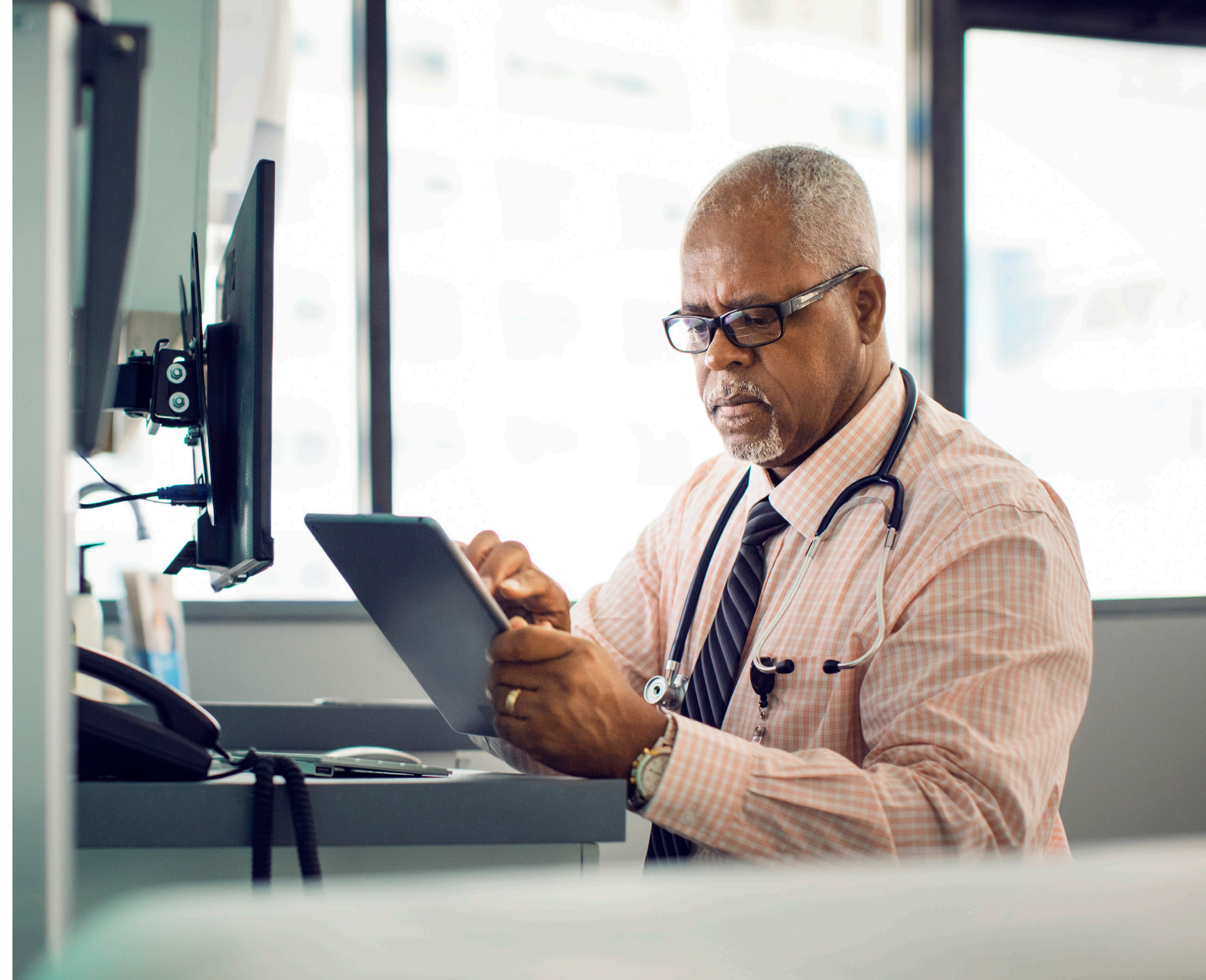
Prior authorization guidelines:

- Please refer to Wellpoint's provider website and the Prior Authorization Look Up Tool (PLUTO) for the most update to date prior authorization guidelines, with some reminders that PLUTO:
  - Is only applicable to outpatient services; all inpatient services require Prior Authorization.
  - Guides for the procedure code alone and does not apply to services billed on the *CMS 1450*, as the Revenue Code may modify the prior authorization requirement. The place of service may also modify the prior authorization rule as well.
  - Does not verify coverage for the member.
  - Additional information is available via PLUTO- including applicable state or Wellpoint medical policies for that service.
- All inpatient claims require prior authorization, including professional services billed on the *CMS-1500*, with places of service that are deemed inpatient, such as Place of Service 21 (Inpatient Hospital)
- All services for out-of-network providers, outside of clearly documented and required emergency services, require prior authorization in advance of the service.
- In instances where members carry other coverage, but Wellpoint is the primary carrier, prior authorization is enforced on claims processing as a standard of practice.

Monitoring submitted claims

After submitting paper or electronic claims, you can monitor and update the claim by:

- Checking claim status on our secure provider website; select Login or Register to access the secure **provider portal**.
- Calling Provider Services at **833-731-2143**.
- Confirming receipt of plan batch status reports from your vendor/clearinghouse to ensure claims have been accepted by Wellpoint.
- Correcting and resubmitting plan batch status reports and error reports electronically.
- Correcting errors and immediately resubmitting to prevent denials due to late filing.



Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims

Field	Box title	Description
1 (R)	Untitled — provider name, address, and telephone number	Name, address, and phone number of the billing facility or service supplier
2	Untitled - pay-to-name, address, and secondary identification fields	Required if pay-to-name and address information is different than billing provider information in the first box
3a	PAT. CNTL #	Member's account number
3b	MED. REC#	Member's record number (up to 20 characters)
4(R)	TYPE OF BILL	**Enter a three-digit number consisting of one digit from each of the following categories in this sequence:** First digit — type of facility Second digit — bill classification Third digit — frequency **Type of facility:** • 1 — Hospital or psychiatric medical institution for children (PMIC) • 2 — Skilled nursing facility (SNF) • 3 — Home health agency • 7 — CORRECTION Rehabilitation agency • 8 — VOID • Hospice **Bill classification:** • 1 — Inpatient hospital, inpatient SNF or hospice (non-hospital based) • 2 — Hospice (hospital based) • 3 — Outpatient hospital, outpatient SNF or hospice (hospital based) • 4 — Hospital referenced laboratory services, home health agency or rehabilitation agency **Frequency:** • 1 — Admit through discharge claim • 2 — Interim — first claim • 3 — Interim — continuing claim • 4 — Interim — last claim
5	FED. TAX NO.	Tax ID is NOT optional.
6	STATEMENT COVERS PERIOD	Month, day, and year (MM/DD/YY format) under both the "from" and "through" categories for the period
7	Blank	No entry required
8a-b	PATIENT NAME	Member last name/first name
9a-e	PATIENT ADDRESS	Complete address (number, street, city, state, zip code and telephone number)
10	BIRTH DATE	Member's date of birth in MM/DD/VY format
11	SEX	Member's gender; enter "M" for male and "F" for female

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims

Field	Box title	Description
12	ADMISSION DATE	Member's admission date to the facility in MM/DD/VY format Inpatient, PMIC and SNF — enter the date of admission for inpatient services Outpatient — enter the dates of service Home health agency and hospice —enter the date of admission of care Rehabilitation agency — no entry required
13	ADMISSION HOUR	Member's admission hour to the facility in military time (00-23) format; required for inpatient/PMIC/SNF. Enter the code that corresponds to the hour the patient was admitted for inpatient care: **Code time (a.m.)** / **Code time (p.m.)** 00 12 - 12:59 / 12 12-12:59 01 1-1:59 / 13 1:59 02 2-2:59 / 14 2:59 03 3-3:59 / 15 3:59 04 4-4:59 / 16 4-4:59 05 5- 5:59 / 17 5-5:59 06 6-6:59 / 18 6-6:59 07 7- 7:59 / 19 7- 7:59 08 8- 8:59 / 20 8-8:59 09 9-9:59 / 21 9-9:59 10 10-10:59 / 22 10-10:59 11 11-11:59 / 23 11-11:59
14	ADMISSION TYPE	Required for inpatient/PMIC/SNF; enter the code corresponding to the priority level of this inpatient admission: 1 — Emergency 2 — Urgent 3 — Elective 4 — Newborn 9 — Information unavailable

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims		
Field	**Box title**	**Description**
15	ADMISSION SRC	Required for inpatient/PMIC/SNF; enter the code that corresponds to the source of this admission: 1 — Non-health care facility point of origin 2 - Clinic or physician's office 4 — Transfer from a hospital 5 — Born inside the hospital 6 — Born outside the hospital 8 — Court/law enforcement 9 — Information not available D — Hospital transfer within the same facility E — Transfer from ambulatory surgical center F — Transfer from hospice
16	OHR (DISCHARGE HOUR)	Required for inpatient/PMIC/SNF; enter the code that corresponds to the hour the patient was discharged from the inpatient care (See field 13 ADMISSION HOUR for discharge hour codes).
17	STAT (PATIENT STATUS)	Required for inpatient/PMIC/SNF; enter the code that corresponds to the status of the patient at the end of service: 01 — Discharged to home or self-care (routine discharge) 02 — Discharged/transferred to other short-term general hospital for inpatient care 03 — Discharged/transferred to an SNF 04 — Discharged/transferred to an intermediate care facility (ICF) 05 — Discharged/transferred to another type of institution for inpatient care or outpatient services 06 — Discharged/transferred to home with care of organized home health services 07 — Left care against medical advice or otherwise discontinued own care 08 — Discharged/transferred to home with care of home IV provider 10 — Discharged/transferred to mental health care 11 — Discharged/transferred to Medicaid certified rehabilitation unit 12 — Discharged/transferred to Medicaid certified substance abuse unit 13 — Discharged/transferred to Medicaid certified psychiatric unit

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims		
Field	**Box title**	**Description**
17	STAT (PATIENT STATUS, continued)	20 — Expired 30 — Remains a patient or is expected to return for outpatient services (valid only for non-diagnosis related group DRG claims) 40 — Hospice patient died at home 41- Hospice patient died at hospital 42 — Hospice patient died unknown 43 — Discharged/transferred to federal health 50 — Hospice home 51 — Hospice medical facility 61 — Transferred to swing bed 62 — Transferred to rehab facility 64 — Transferred to nursing facility 65 — Discharged/transferred to psychiatric hospital 71 — Transferred for another outpatient facility 72 — Transferred for outpatient service
18-28	CONDITION CODES	Enter the corresponding condition code to indicate whether treatment billed on this claim is related to any condition listed below; up to seven codes may be used to describe the conditions surrounding a patient's treatment: **General** 01 — Related to military service 02 — Condition is related to employment 03 — Patient covered by an insurance not reflected here 04 — HMO enrollee 05 — Lien has been filed **Inpatient only** X3 — Iowa Foundation for Medical Care (IFMC)-approved lower level of care, intermediate care facility (ICF) X4 — IFMC-approved lower level of care, skilled nursing facility (SNF) 91 — Respite care **Outpatient only** 84 — Cardiac rehabilitation program 85 — Eating disorder program 86 — Mental health program 87 — Substance abuse program 88 — Pain management program 89 — Diabetic education program 90 — Pulmonary rehabilitation program 98 — Pregnancy indicator — outpatient or rehabilitation agency

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims		
Field	**Box title**	**Description**
18-28	CONDITION CODES (continued)	Special program indicator AI — EPSDT A2 — Physically disabled children's program A3 — Special federal funding A4 — Family planning AS — Disability A6 — Vaccine/Medicare 100 percent payment A7 — Induced abortion - danger to life A8 — Induced abortion — victim rape/incest A9 — Second opinion surgery
29	ACDTSTATE	No entry required
30	Blank	No entry required
		Required if any of the occurrences listed below are applicable to this claim; enter the corresponding code and the month, day, and year of that occurrence **Accident related** 01 — Auto accident 02 — No fault insurance involved, including auto accident/ other 03 — Accident/tort liability 04 — Accident/employment related 05 - Other accident 06 — Crime victim **Insurance related** 17 — Date outpatient occupational plan established or reviewed 24 — Date insurance denied 25 — Date benefits terminated by primary payer 27 — Hospice certification date A3 — Medicare benefits exhausted **Other** 11 — Date of onset
35-36	OCCURRENCE SPAN (CODE, FROM AND THROUGH)	No entry required
37	Blank	No entry required
38	Blank	No entry required
39-41	VALUE CODES (CODE AND AMOUNT)	Required; enter the value code followed by the number of covered and/or noncovered days that are included in the billing period. Note: There should not be a dollar amount in this field. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. 80 — Covered days 81 — Noncovered days

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims		
Field	**Box title**	**Description**
42	REV. CD.	Revenue codes are required for all institutional claims; enter the revenue code that corresponds to each item or service billed.
43	DESCRIPTION	Required if the provider enters an HCPCS "J-code" for a drug that has been administered; enter the national drug code (NDC) that corresponds to the J-code entered in field 44. The NDC must be preceded with an "N4" qualifier. NDC should be entered in NNNNN-NNNN-NN format. No other entries in this field.
44	HCPS/RATE/HIPPS CODE	Required for outpatient hospital, inpatient SNF, and home health agencies: **Outpatient hospitals** — enter the HCPCS/CPT® code for each service billed, assigning a procedure, ancillary or medical APC **Inpatient SNF** — enter the HCPCS code W0SII for ventilator-dependent patients, otherwise leave blank **Home Health Agencies** — enter the appropriate HCPCS code from the prior authorization when billing EPSDT-related services **All Others** — leave blank **DO NOT ENTER RATES IN THIS FIELD.** Note: When applicable, a procedure code modifier should be displayed after the procedure code.
45	SERV. DATE	Required for outpatient claims; enter the service date for outpatient service referenced in Field 42 or Field 44. Note that one entry is required for each date in which the service was performed.
46	SERV. UNITS	Required for inpatient, outpatient, and home health agencies: **Inpatient** — Enter the appropriate units of service for accommodation days. **Outpatient** — Enter the appropriate units of service provided per CPT/revenue code (Note: Batch bill APGs require one unit= 15 minutes of service time). **Home health agencies** — Enter the appropriate units for each service billed; a unit of service is equal to one visit. One unit of prior authorization private duty nursing/ personal care is one hour. All units should be entered using whole numbers only (1). Do not indicate partial units (1.5) or anything after the decimal (1.0).
47	TOTAL CHARGES	Total charge for each line of service being billed; must include both dollars and cents
48	NON-COVERED CHARGES	Enter any noncovered charges for each applicable line; the total must include both dollars and cents
49	Blank	No entry required
50	PAYOR NAME	Payer identification; enter any third-party payers

Recommended fields for the *CMS-1450 (UB-04)* form — institutional claims		
Field	**Box title**	**Description**
51	HEALTH PLAN ID	Medicare provider ID number/unique provider ID number; the billing provider number is required
52	REL.INFO	Release of information certification indicator
53	ASG BEN.	Assignment of benefits certification indicator
54	PRIOR PAYMENTS	Required if a payer made prior payments other than Medicaid; if applicable, enter the amount paid by a payer other than Medicaid. **Do not enter previous Medicaid payments.** Note: If more than one claim form is used to bill services performed and a payer payment was made, the third-party payment should be entered on each page on the claim in field 54.
55	EST. AMOUNT DUE	No entry required
56	NPI	The NPI number of the billing entity
57	OTHER PRIV ID	The other provider ID, if applicable
58	INSURED'S NAME	Member's name
59	P. REL	No entry required
60	INSURED'S UNIQUE ID	Insured's ID number: this is the certificate number on the member's ID card. For newborns, use the mother's ID number for services during the month of birth and the month following.
61	GROUP NAME	Insured group name; enter the name of any other health plan.
62	INSURANCE GROUP NO.	Policy number of any other health plan
63	TREATMENT AUTHORIZATION CODES	Authorization number or authorization information (if applicable)
64	DOCUMENT CONTROL NUMBER	No entry required
65	EMPLOYER NAME	Name of organization from which the insured obtained the other policy
66	DX/PROC Qualifier	Enter the diagnosis and procedure core qualifier (ICD version indicator). Enter "0" for ICD-10.
67	DX	Principal diagnosis codes; enter ICD-10 diagnostic codes, if applicable
67a-q	DX	Other diagnosis codes; enter ICD-10 diagnostic codes, if applicable
68	Blank	No entry required
69	ADMIT DX	Required for inpatient hospital claims (admitting diagnosis is required)
70a-c	PATIENT REASON DX	Required if visit is unscheduled; the patient's reason for the visit is required for all unscheduled outpatient visits for outpatient bills.
71	PPS CODE	No entry required
72	ECI	No entry required
73	Blank	No entry required
74	PRINCIPAL PROCEDURE CODE/DATE	Required for the principal surgical procedure; enter the appropriate ICD-CM procedure code and surgery date, when applicable.
74a-e	OTHER PROCEDURE CODE/DATE	Required for additional surgical procedures; enter the appropriate ICD-CM procedure codes and surgery dates.
75	Blank	No entry required
76	ATTENDING	NPI of the attending physician Outpatient - Enter the NPI of the referring physician; this area should not be completed if the primary physician did not give the referral. Do not show treating physician information in this area.
77	OPERATING	Required if the physician performing the principal procedure is different than the attending physician; enter the NPI of the operating physician.
78-79	OTHER	Any other provider numbers, if applicable
80	REMARKS	Required if a diagnosis other than the principal is made, when applicable enter one of the following: • "Not a Medicare benefit" • "Resubmit" (and list the original filing date) • "Member is retro-eligible and NOD (notice of decision) is attached."
81a-c	cc	Required; enter taxonomy code associated with the NPI of the billing entity (Field 56). Precede taxonomy code with qualifier "B3" (health care provider taxonomy code) Note: The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment.

Recommended fields for the *CMS-1500* form — professional claims

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Field #	Box title	Description
1	INSURANCE CARRIER SELECTION	Check the applicable program
1a	INSURED'S ID NUMBER	FOR PROGRAM IN ITEM 1 — enter the member's Medicaid number found on the Wellpoint member identification card
2	PATIENT'S NAME	The member's last name, first name, and middle initial
3	PATIENT'S BIRTH DATE	Member's birth date in MM/DD/YY format (Optional: SEX - enter X in the appropriate box.)
4	INSURED'S NAME	Last name, first name, middle initial; for Medicaid, this is always the same as the patient identified in box 2.
5	PATIENT'S ADDRESS	Patient's complete address information and telephone number, including the area code (optional)
6	PATIENT RELATIONSHIP TO INSURED	Not applicable
7	INSURED'S ADDRESS	Not applicable
8	RESERVED FOR NUCC Use	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	If the Medicaid member is covered under additional insurance, enter the name and policy holder of that insurance as well as the policy or group number, the employer or school name under which the coverage is offered and the name of the plan or program. Note: If 11d is "Yes", these boxes must be completed.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	If the Medicaid member is covered under additional insurance enter the name and policy holder of that insurance. Note: if 11d is "Yes", this box must be completed.
9b	RESERVED FOR NUCC USE	Leave blank
9c	RESERVED FOR NUCC USE	Leave blank
9d	INSURANCE PLAN NAME OR PROGRAM NAME	If the Medicaid member is covered under other additional insurance enter the name and policy holder of that insurance. Note: if 11d is "Yes", this box must be completed.
10	IS PATIENT'S CONDITION RELATED TO:	Required if known; check the appropriate box to indicate whether treatment billed on this claim is for a condition that is somehow work- or accident-related. If the patient's condition is related to employment or an accident and other insurance has denied payment, complete 11d, marking the "Yes" and "No" boxes. The provider also needs to include the appropriate postal abbreviation for the PLACE (state) associated with the auto accident.
10a	EMPLOYMENT (CURRENT OR PREVIOUS)	
10b	AUTO ACCIDENT	
10c	OTHER ACCIDENT	
10d	CLAIM CODES	No entry required
11	INSURED'S POLICY GROUP OR FECA NUMBER	For Medicaid, the insured is always the same as the patient (optional)
11a	INSURED'S DATE OF BIRTH	Member's birth date in MM/DD/YY format (optional)
11b	OTHER CLAIM ID	No entry required
11c	INSURANCE PLAN NAME OR PROGRAM NAME	For Medicaid, the insured is always the same as the patient (optional)

Recommended fields for the *CMS-1500* form — professional claims		
Field #	**Box title**	**Description**
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required if the Medicaid member has other insurance; check "Yes" and enter payment amount in field 29. If "Yes", then boxes 9a-9d must be completed. If there is no other insurance check "No". If you have received denial of payment from another insurance, check both "Yes" and "No" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in payment of record.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	No entry required
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	No entry required
14	DATE OF CURRENT ILLNESS (first symptom date) OR INJURY (accident date) OR PREGNANCY (LMP date)	Entry should be made in MM/DD/YY format; required for chiropractors. Chiropractors use the date of onset of current symptoms or illness. For pregnancy, use the date of the last menstrual period (LMP). This field is not required for preventative care. Qualifier 484 should be used when entering the date of the LMP. Qualifier 431 should be used when entering the date for onset of current symptoms or illness.
15	OTHER DATE	Required for chiropractors; chiropractors MUST enter the date of the most current X-ray. Entry should be made in MM/DD/VY format. Note: Qualifier 455 must be used when indicating the X-ray date.
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	No entry required
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	First name, middle initial, last name of the referring provider, ordering provider or other source
17a	ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER OR OTHER SOURCE	No entry required
17b	NPI	Enter the 10-digit numeric NPI of the referring provider, ordering provider or other source; required if applicable.
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	No entry required
19	ADDITIONAL CLAIM INFORMATION	Designated by NUCC — not applicable
20	OUTSIDE LAB?	Not applicable (CHARGES — not applicable)
21 A-L ICD Indicator	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Complete fields 21A-L through field 24E by detail line. Enter the ICD diagnosis codes in priority order. A total of 12 codes can be entered (required).
22	RESUBMISSION CODE, ORIGINAL REF. NO.	• For re-submissions or adjustments, enter the original claim number of the original claim. • New form — for resubmissions only: – 7 — Replacement of Prior Claim – 8 — Void/cancel prior claim and then you can also add in the Medicare Crossover information.
23	PRIOR AUTHORIZATION (PA) NUMBER	Enter the authorization or referral number. CLIA number for CLIA waived or CLIA certified laboratory services.

Recommended fields for the *CMS-1500* form — professional claims		
Field #	**Box title**	**Description**
24A Top half	DATE(S) OF SERVICE/NOC	Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCS). Note: No spaces or symbols should be used in reporting this information.
24A Bottom half	DATE(S) OF SERVICE	Enter month, day, and year under both the "From" and "To" categories for each procedure, service, or supply. Entry should be made in MM/DD/VY format.
24B Bottom half	DATE(S) OF SERVICE	Using the chart below, enter the number corresponding to the place service was provided. DO NOT USE alphabetic characters. 11 — Office 2 —Home 21 — Inpatient hospital 22 — Outpatient hospital 23 — Emergency room — hospital 24 — Ambulatory surgical center 25 — Birthing center 26 — Military treatment facility 31 — Skilled nursing 32 — Nursing facility 33 — Custodial care facility 34 — Hospice 41 — Ambulance (land) 42 — Ambulance (air or water) 51 — Inpatient psychiatric facility 52 — Psychiatric facility (partial hospitalization) 53 — Community mental health center 54 — Intermediate care facility/mentally retarded 55 — Residential substance abuse treatment 56 — Psychiatric residential treatment center 61 — Comprehensive inpatient rehabilitation facility 62 — Comprehensive outpatient rehabilitation facility 65 — End-stage renal disease treatment 71 — State or local public health clinic 81 — Independent laboratory 99 — Other unlisted facility
24C	EMG	No entry required
24D	PROCEDURES, SERVICES OR SUPPLIES	CPT/HCPCS — Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line (required). MODIFIER — Use the appropriate modifier, if applicable. Up to four modifiers are allowed for each procedure code (required if applicable).

Recommended fields for the *CMS-1500* form — professional claims		
Field #	**Box title**	**Description**
24E	DIAGNOSIS POINTER	Enter letter A-L corresponding to the applicable diagnosis codes in field 21. A minimum of one and a maximum of four diagnosis code references can be entered on each line (required).
24F	$ CHARGES	The total amount charged for the procedure performed, based on the number of units indicated in field 24G. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines. This is a 10-digit field (required).
24G	DAYS OR UNITS	The number of units being claimed for the procedure code; six digits are allowed, and 9999.99 units is the maximum that can be submitted. The procedure code may be submitted in partial units, if applicable (required).
24H	EPSDT FAMILY PLAN	If the patient is pregnant, indicate with a Pin this field on each applicable line (required if applicable).
241 Top half shaded area	RENDERING ID QUALIFIER	No entry required
24J Top half shaded area	RENDERING PROVIDER ID	No entry required
24J Bottom half	RENDERING PROVIDER NPI	NPI of the rendering provider (required if applicable)
25	FEDERAL TAX ID NUMBER	Not applicable
26	PATIENT'S ACCOUNT NUMBER	Internal patient tracking number (optional)
27	ACCEPT ASSIGNMENT	No entry required
28	TOTAL CHARGE	Total of all service line charges in column 24F
29	AMOUNT PAID	Required if the member has other insurance and the insurance has made a payment on the claim. Enter only the amount paid by other insurance. Member copays, Medicare payments or previous Medicaid payments are not listed on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denials must be included in the patient record. If more than one claim form is used to bill services performed or a prior payment was made, the third-party payment should be entered on each page of the claim in Box 29.

Recommended fields for the *CMS-1500* form — professional claims		
Field #	**Box title**	**Description**
30	RESERVED FOR NUCC USE	No entry required
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Enter the signature of either the physician or authorized representative and the original filing date. If the signature is computer-generated block letters, the signature must be initialed (Note: A signature stamp may be used). 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 form.
32	SERVICE FACILITY LOCATION	Complete address of the treating/rendering provider
32a	NPI	NPI of the facility where service(s) were rendered
32b	SERVICE FACILITY LOCATION QUALIFIER AND ID NUMBER	No entry required
33	BILLING PROVIDER INFO AND PHONE#	Provider service location name, address, and the ZIP code+4, as listed on the provider enrollment profile (required)
33a	BILLING PROVIDER NPI	Billing provider NPI (required)
33b	BILLING PROVIDER QUALIFIER AND ID NUMBER	Taxonomy code associated with the billing provider's NPI; a "ZZ" qualifier must precede the taxonomy code

Notice

This manual is not intended to cover all claims and billing requirements. For more information about requirements, benefits, and services, visit **provider.wellpoint.com/ia** to get the most recent version of our provider manual. If you have questions about this manual or recommendations to improve it, please call Provider Services at **833-731-2143**. We would love to hear from you.

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