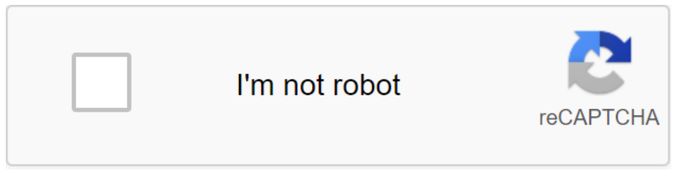
# Gboard apk android 4.4

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The standard form of CMS 1500 or health insurance claim is a document used by a non-compliant supplier or supplier to bill medical carriers and medical equipment if the supplier is entitled to waive the requirement of the Administrative Simplification Act for electronic filing of claims. The CMS 1500 form can also be used to bill state Medicaid agencies. For consistency with electronic transactions, the form meets the requirements of the X12 Accredited Standard Committee (ASC X12) Health Claim: Professional (837P) Version 5010 Technical Reports Type 3 (TR3s). The top half of the form 1500 is designed for the patient's information when the bottom half should be completed by the doctor. Provide the patient's name, address, city, zip code and contact number. Separate the corresponding boxes. Add a signature. The doctor must put the date of illness, injury, etc. Write more information about the claims. Describe the diagnosis. Enter the federal identification number, patient account number, and location information. What is the total amount of payment as well as the amount paid. Add a signature. You can send the form to Medicare, Medicare Or A/B MAC' medical equipment contractor electronically using a software device that meets the requirements of the online application set by hipAA's claim and certain CMS requirements. For more information, contact the State Medicaid Agency. Online systems help you manage documents and improve the productivity of your workflow. Follow a quick guide with the intention of completing the CMS 1500 Claim form, refrain from malfunctioning and submit it in a timely manner: How to finish cms 1500 form? The site along with the view, just click Start Now and go to the editor. Use hints to complete the applicable fields. Include your personal information and facts and contact information. Make it a positive that you just enter the right knowledge and quantity in ideal areas. Take a close look at the content of the material of your form, in addition to grammar and spelling. Contact that will help segment for those who have any doubts or deal with our help staff. Place an electronic signature on your own CMS 1500 Claim form using the Sign Resource guide. Once the form is complete, click Finish. Distribute the finished variety by email or fax, print it out or keep it in your system. The PDF editor allows you to definitely make changes to the CMS 1500 Claim form from any web gadget, customize it according to yours instructing it electronically and distributing it by a variety of means. Download the CMS 1500 claim form, which is used by health care providers to bill Medicare and Medicaid. In addition to Medicare parts A/B and for Medicare durable medical equipment administrative contractors. Claims Claim 12 months after services are provided. How to write Step 1 - Section 1 - Complete the information in the following blocks: 1. Select the insurance group you use and check the field that applies 1.a. - Provide the insured identification number 2. The patient's name (last, first, middle initial) 3. Patient's date of birth (mm/dd/yyyy) Sex (check one) 4. The name of the insured (last, first, middle initial) 5. Patient address (number and street) - City, State, Tzip and phone number (including district code) 6. Patient's relationship with insured 7. Address of the insured (number and street)-City, State, Tzip and phone number (including district code) 8. Patient's condition (marriage) (check 1) 9. The name of another insured (last, first, middle initial) 9a. Policy of other insured or group number b. Other insured date of birth (mm/DD/yyyy) sex (check one) 9c. Employer's name or school name 9d. The patient's condition is related to (current or previous) (check field (s) that apply) 11. Insurance Policy Group or FECA number 11a. Insured date of birth (mm/dd/yyyyyy) Sex (check one) 11b. Employer's name or school name 11c. Insurance plan name or program name 11d. (Check one-if-yes back to and complete 9 athrough d) 12. Read the back of the form before filling out and signing this form - Once the information has been reviewed, place your signature on the line and enter the date mm/dd/yyyy 13. Signature of the insured or authorized person Step 2 - Information about the patient's illness or injury 14. Date of current (mm/dd/yyyy) illness, injury, pregnancy, etc. 15. If the patient has or has had the same or similar illness, give a first date - mm/dd/yyyy 16. Dates patient will not be able to work in the current class From: mm/dd/yyy to mm/dd/yyy 17. Name referring to provider or other source 17a. (source) 17b. NPI 18. Hospitalization dates associated with current services From: mm/dd/yyyyy - To: mm/dd/yyyy 19. RESERVED FOR LOCAL USE 20. Outside the lab? What are the charges? 21. Diagnosis or nature of illness or injury (include paragraphs 1.2.3 or 4 to paragraph 24 E by line 22. Medicaid Resupmission 23. Pre-resolution Number 3 - Section 24- Full 24a. via 24j. 25. Federal Tax Identification Number (SSN or EIN) 26. Patient Account Number 27 Take? (check yes or no) 28. Total charge 29. The amount paid is 30. Balance is due to 31. Signature and Date mm/dd/yyyy 32. Object Location Information Service 33. a. and b. Billing provider information and phone numbers (with area code) As video CMS-1500 form complete and tracking software Full, save, print, submit in Kind, then track the CMS-1500 form for medical care treatment, TOP RIGHT SIDE FROM CMS-1500 should be BLANK. Notes, comments, addresses or any other in this area, the form will result in the claim being returned to the unprocessed. Block 1 Show all types (s) health insurance applicable to this claim by checking the appropriate box (es). Block 1a INSURED'S ID NUMBER - Enter the patient's Medicare number if applicable. The 11-digit Patient Care Number (Recipient) of Maryland is required in Block 9a. - Situational. Block 2 PATIENT'S NAME (Family, Name, Middle Initial) - Enter the patient's name (recipient) as it appearsBlock 24C EMG - Leave empty. Block 3 PATIENT'S BIRTH DATE/SEX - Enter the date of birth and gender of the patient (recipient). You don't have to. Block 4 INSURED'S NAME ( Family, Name, Middle Initial) - Enter the name of the person whose name is listed third party coverage only if applicable. You don't have to. Block 5 PATIENT'S ADDRESS - Enter the patient's full postage address (recipient) with postcode and phone number. You don't have to. Block 6 PATIENT'S RELATIONSHIP TO INSURED - Enter appropriate relationships only when there is a third party health insurance other than Medicare and Medicaid. You don't have to. Block 7 INSURED'S ADDRESS - When there is third-party health insurance other than Medicare and Medicaid, enter the insured's address and phone number. You don't have to. Block 8 RESERVED FOR NUCC USE - no entry is required. Block 9 OTHER INSURED'S NAME - No entry is required. Block 9a OTHER INSURED'S POLICY OR GROUP NUMBER - Enter Maryland's 11-digit health care number as it appears on the MA map. The MA number should be displayed in this block regardless of whether the recipient has other insurance. The eligibility for medical care must be checked for each date of service by EVS. EVS works 24 hours a day, 365 days a year on the following number: 1-866-710-1447- Mandatory Block 9b RESERVED FOR NUCC USE - Entry is required. Block 9c RESERVED FOR NUCC USE - Entry is not required. Block 9d INSURANCE PLAN OR PROGRAM NAME - Enter the name of the insured group and group number only when there is third-party health insurance other than Medicare and Medicaid. You don't have to. Block 10a IS PATIENT'S CONDITION RELATED TO - Check Yes or No to indicate whether employment, auto-injury or other accident involvement applies to one or more services described in paragraph 24 if this information is known. If not known, leave empty. You don't have to. Block 10d CLAIM CODES - When billing for abortions or abortion-related services, enter the corresponding state code of two alpha symbols (AA-AH) from the table below. This area should be the only one for abortions and abortions associated with services, otherwise left empty. AA (a) Abortion performed because of the Rape Code indicates an abortion performed as a result of rape. AB (a) Abortion performed due to The Code refers to an abortion performed in connection with an incest incident. AC(a) Abortion performed due to a serious genetic defect of the fetus, deformity or anomaly of the code indicates an abortion performed due to a genetic defect, deformity, or abnormality for the fetus. AD (a) Abortion performed because of the code of physical condition that threatens life indicates an abortion performed because of life, endangering the physical condition caused, arising or exacerbated by the pregnancy itself. AE(a) Abortion performed because of the physical health of the mother, which is not a life-threatening code, indicates an abortion performed because of the physical health of the mother, which is not life-threatening. AF (a) Abortion performed in connection with the emotional/psychological health of the Maternal Code indicates an abortion performed on the condition of the mother's emotional/psychological health. AG (b) Abortions performed for social or economic reasons indicate abortion for social or economic reasons. AH (b) Elective Abortion Elective Abortion. (a) CMS1500 claims that report AA-AF abortion codes are covered by Medicaid and do not require the attachment of DHMH 521. These claims can be put electronically Maryland Medicaid for payment. Form DHMH 521-Certification for abortion must be completed and stored in the patient's medical records. (b) CMS1500 claims reporting the status of AG and AH abortions are not

covered by Medicaid. Block 11 INSURED'S POLICY GROUP OR FECA NUMBER - If the recipient has another third party of health insurance and the claim has been rejected by this insurance, enter the relevant waiver code listed below: For information about the recipient's coverage, contact a third party in liability Unit at 410-767-1765. - Required CODE REJECTION REASONS K Services not covered by L Coverage Lapsed M Coverage Not valid on the service date N Individual not covered - The claim is not filed in a timely manner (requires documentation, for example, a copy of the waiver from the insurance company.) R No response from the carrier within 120 days of filing a claim (requires documentation, such as a statement indicating the submission of the claim, but not the answer.) S Other reasons for failure are not defined above (requires documentation, such as a claim statement indicating that the payment was applied to the deductible.) Block 11a INSURED's DATE OF BIRTH - Entry is not required. Block 11b OTHER CLAIM ID - Entry is not required. Block 11c INSURANCE PLAN OR PROGRAM NAME - Entry is not required. Block 11D IS THERE ANOTHER BENEFIT PLAN? There is no need to enter. Block 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - No entry is required. Block 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - no entry is required. Block 14 DATE CURRENT ILLNESS, INJURY, PREGNANCY - Entry is not required. Block 15 OTHER DATE - No entry is required. Block 16 DATES PATIENT NOT WORK IN CURRENT OCCUPATION - Entry is not required. Block 17 NAME links links OTHER SOURCE - Note: Completion of 17-17b is required only for laboratory and other diagnostic services. Completion is optional if a valid medical care individual practitioner identification number is entered into the #17a block. Don't file an invoice if there is no order in the file that checks the identity of the practitioner. - Situational Block 17a (Grey Id Shaded Area) NUMBER FROM THE BEST PHYSICIAN - Enter ID qualifier - 1D (Medicaid provider number) and then provider's 9-digit Medicaid provider number. - Mandatory Block 17b Enter NPI Links, Order or Supplier Oversight listed in Block 17. - Required unit 18 hospitalization DATES RELATED TO CURRENT SERVICES - Entry is not required. Block 19 ADDITIONAL CLAIM INFORMATION - No record required Block 20 OUTSIDE LAB - Optional 21 DIACDIA or NATURE FROM ILLNESS or INJURY - Enter the applicable ICD indicator to determine which version of the ICD codes are reported. Enter the indicator between vertical, dotted lines at the top right of the field. 9 ICD-9-CM 0 ICD-10-SM Enter the symbol code 3-5 alpha/number from ICD-9, related to procedures, services or accessories listed in Block #24e. List the primary diagnosis on line A, with any follow-up codes that will be entered on lines B through H (highest level of specificity in priority order). Additional diagnoses are optional and can be listed on Lines I via L. - Note required: From April 1, 2014, medical care (MA) will only take a revised form of CMS-1500 (02-12) with ICD-9 codes. We do not report ICD-10 codes for claims with service dates until October 1, 2014. The program will accept ICD-9 or ICD-10 codes depending on the date of service in the revised form. REMINDER: ICD-9 and ICD-10 codes cannot be registered in the same claim form. Block 22 MEDICAID RESUBMISSION - Entry is not required. Block 23 PRIOR AUTHORIZATION NUMBER - For those services that require prior authorization, you need to get a pre-authorization number and hang it in this block. - Mandatory Block 24 A-G (Grey Shaded Area) NATIONAL DRUG CODE (NDC) - Report nDC/number when billing drugs using J-code HCPCS. Allow 61 characters to enter from start 24A to end 24G. Start by entering the N4 qualifier and then the 11-digit NDC number. Perhaps, in order to report eleven digits (5-4-2), you may need to put NDC numbers with left-tral zeros. Without missing space or adding a hyphen, enter the measurement qualifier unit followed by the numerical amount administered to the patient. Below are the qualifying measurements when reporting on NDC units: F2 Qualifiers International Group GR Gram ML Un Units (EA/Everyone) ME Milligram More Than One NDC May Be in the shaded lines of Box 24. Skip three spaces after the first NDC/number is reported, and enter the next NDC qualifier, NDC number, unit qualifier, and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDC's. - Required NOTE: These instructions detail only those data items for medical care (MA) paper billing claim. For e-billing, please refer to the Maryland Medicaid 837-P Electronic Companion Guide, which can be found on our website: dhmh.maryland.gov/hipaa/SitePages/transandcodesets.aspx Block 24A DATE (S) SERVICE - Enter each individual service date as a 6-digit numerical date (e.g., June 1, 2005 will be 06/01/05) under the heading FROM. Leave the space under the TO header empty. Each service date for which the service was provided must be listed on a separate line. Date ranges are not accepted in this form. - Mandatory Block 24B PLACE OF SERVICE - For each service date, enter the corresponding 2-digit service location code listed below to describe the site. - Mandatory Code Location 03 School 42 Ambulance - Air or Water 11 Management 50 Federally Qualified Health Ctr. 12 Patient Residence 51 Inpatient Psychiatric Facility 20 Emergency Care 52 Psychiatric Institution Partial Hospitalization 21 Inpatient Hospital 53 Ctr Community Mental Health. 22 Outpatient Hospital 56 Psychiatric Inpatient Treatment Ctr. 23 Ambulance - Hospital 57 Non-Residential Substance Abuse 24 Outpatient Surgical Ctr. 61 Comprehensive Inpatient Rehabilitation Ctr. 25 Birth Ctr 62 Comprehensive Outpatient Rehabilitation. Ctr 26 Military Treatment Ctr 65 End Of Stage Renal Disease Treatment Fund 31 Skilled State Medical Center or Local Public Health Clinic 32 Nursing Home 72 Rural Clinic 33 Patient Care 81 Independent Laboratory 34 Hospice 99 Other unregistered Facility 41 Ambulance - Land Block 24C EMG - Leave empty. Block 24D PROCEDURES, SERVICES OR SUPPLIES - Enter the procedure code of five characters describing the service provided and the two characteristic Modifier Block 24E DIAGNOSIS POINTER - Enter a single or combination of diagnostic elements (A thru H) from the block #21 higher for each line on the invoice. Note required: The program recognizes only up to eight (8) A-H pointers. Block 24F CHARGES - Enter regular and regular fees. Don't enter Maryland Medicaid maximum fee if it's your regular and regular charge. If there is more than one service unit on the line, the fee for that line should be a total of all units. - Mandatory Block 24G DAYS OR UNITS - Enter the general units of service for each procedure. The number of units must be for one visit or a day. Several identical services provided on different days must be displayed on separate lines. - Note required: Several identical services for radiological or pathological services within the code range of PPC 70000-89999, rendered on the same day, must be combined and entered on the same line. Block 24H EPSDT FAMILY PLAN - Leave empty. Block 24I ID. A QUALIFIER. - Enter ID 1D (Medicaid Provider Number) - Mandatory NOTE: This double-digit qualifier determines the non-NPI number followed by the identification number. If you need to specify the 9-digit number of the provider's MA provider, the 1D ID qualifier must precede that number. Block 24J (grey RENDERING PROVIDER ID - Enter the 9-digit number of the ma supplier of the shaded area) of the practitioner providing the service. In some cases, the rendering number may be the same as the pay-#33 provider's number. Enter the NPI rendering provider in a non-border area. - Mandatory Block 25 FEDERAL TAX ID NUMBER - Optional. Block 26 PATIENT'S ACCOUNT NUMBER - You can enter an alphabetical, alpha number or numerical patient account ID (up to 13 characters) used by the provider's office. If the recipient's master's number is incorrect, this number will be recorded for a money transfer consultation. You don't have to. Block 27 ACCEPT ASSIGNMENT? - To pay for medicare coinsurance and/or deductibles, this unit must be inspected yes. Service providers agree to accept Medicare and/or Medicaid as a condition of participation. - Required NOTE: The rules state that providers must accept payment by the Program as payment in full for services rendered and not charge an additional fee to any recipient for services covered by insurance. Block 28 TOTAL CHARGE - Enter the amount of fees shown on all Block lines #24F invoices. - Mandatory Block 29 SUMMA PAID - Enter the amount of any collections received from any third payment participant, EXCEPT Medicare. If the recipient has third party insurance and the claim has been rejected, the relevant waiver code is placed in block 11. - Situational NOTE: The program does not consider Medicare as a third party payment. Block 30 RESERVED FOR NUCC USE - Entry is not required. BLOCK 31 IS THE SIGNATURE OF A DOCTOR OR SUPPLIER, INCLUDING A DEGREE OR CREDENTIALS - OPTIONAL. NOTE: A filing date must be entered here in order for the claim to be reimbursed. Unit 32 SERVICE FACILITY LOCATION INFORMATION - Complete only if the billing for medical laboratory services is sent to another laboratory or facility where trauma services were provided. Enter the name and address of the object. - Situation unit 32a NPI - Enter the NPI number of the object. - Mandatory Block 32b (Grey Shaded Area) Enter ID qualifier 1D (Medicaid provider number) and then 9-digit provider number maryland Medicaid facility. - Required NOTE: The program will not pay referring to the lab laboratory services transferred to a reference laboratory that is not registered. Referring to the laboratory also not to issue a bill to the recipient for medical laboratory services, citing the non-participation of the reference laboratory. Block 33 BILLING PROVIDER INFO - Enter the name, full address of the street, city, state and postcode provider. This should be the address at which the claims can be returned. - Mandatory Block 33a NPI - Enter the billing provider's NPI number in block 33. Errors or omissions of this number will result in non-payment of requirements. - Mandatory Block 33b (Grey Enter ID 1D (Medicaid Provider Number) and then Shaded Area) 9-digit supplier number MA supplier in Block #33. Errors or omissions of this number will result in non-payment of requirements. Note required: The Supplier is responsible for promptly reporting any changes to the name, payment address, address of correspondence, place of practice, tax identification number or certification to the vendor registration office at 410-767-5340. Claim Completion of CMS 1500 Fast Guide To Pre-Authorization Number: Enter a nine-digit Medicaid authorization number for services requiring permission. Check out the policy guide for specific requirements. Below are some of the services that require permission: Choose of inpatient services Out-of-state ambulance transportations Choose medical equipment and materials Choose prosthetic and orthopedic services Choose Vision Services Transplant Services Other services described in the guide to supplier policy or Medicaid databases. Clinical Laboratory Services: Enter the CLIA number here when billing for clinical laboratory services. The CLIA number is a 10-digit number with A D in the third position necessarily: An item is required for all claims. If the item is left empty, the claim cannot be processed. Conditional: A clause is required if applicable. Your claim cannot be processed if empty. Information on the status of paragraph 1a Mandatory Enter the 8-digit Medicaid patient identification number. 2 Be sure to enter the patient's surname, first name, middle initial, if any. 3 Be sure to enter the patient's 8-digit date of birth (MMDDCCYY) and gender. 4 Conditional, mandatory if the patient has primary Medicaid coverage. 6 Conditionally, if paragraph 4 is completed, check the appropriate box. 7 Conditional complete if elements 4 and 11 are completed. 9 Conditionally, necessarily if paragraph 11d. is YES. 9a Conditional Enter the second insurance policy or group number for the insurer in paragraph 9. 9b Conditional date of birth (MMDDCCYY) and floor for insurer in paragraph 9. 9c Conditional Enter Employer or School Name for Insurer in paragraph 9. 9d Conditional name of the Insurance Plan Enter or the name of the program for the insurer in paragraph 9. 10a Mandatory check YES or NO if the condition is related to employment. 10b Mandatory CHECK YES or NO if condition With a car accident. If so, enter the state postcode. 10c Mandatory CHECK YES or NO if related to the accident, except the car. 11 Conditional mandatory if the patient has primary Medicaid coverage. Enter the primary insurance group number. 11a Conditional enter the date of birth (MMDDCCYY) and gender for the insurer in paragraph 4. 11b Conditional enter the name of the employer or school for the insurer in paragraph 4. 11c Conditional Enter an insurance plan or program name for the insurer in paragraph 4. 11d Conditional YES check, if appropriate and complete 9-9d elements. 14 Conditionally, If paragraph 10b or 10c yes, the date of the accident must be reported. 17 Conditionally enter the name of the doctor to which the name is referred/ordered, as necessary. 17a Conditional Enter a 9-digit Medicaid provider ID provider in paragraph 17. 17b Mandatory Enter NPI 18 Conditional Report that during hospital stays, discharge dates for services are allowed. 19 If necessary conditional documentation or comments Enter. 21 Be sure to enter the ICD-9-CM diagnostic code, which determines the reason for the service. 22 Conditional code re-entering 7 - the last paid 10-digit CRN is mandatory to replace the previously paid claim. Re-approval of Code 8 - the last paid 10-digit CRN is mandatory for annulment/cancellation of a previously paid claim. 23 Conditional Enter a nine-digit Medicaid authorization number or a ten-digit CLIA number as needed. 24A Mandatory Enter Eight-Digit (MMDDCCYY) 'from' and 'up' dates for each service. 24B Be sure to enter the appropriate double-digit service code location. 24C Mandatory Enter code EMG Y is an emergency or N unless an emergency 24D mandatory entry code and modifier (if necessary) for procedure, maintenance or delivery rendered. 24E Mandatory Enter reference number (s) from paragraph 21, which relates to procedure/service. First, tell us the number of the initial diagnosis. 24F Mandatory Enter your charge without decimal signs, commas or dollar signs. 24G Mandatory Enter number of units. 24H EPSDT Medicaid does not use. 24I Conditional ID ID use ID if reflects the outdated vendor ID 24J Mandatory enter the medical director in NPI'NPI gboard apk android 4.4.2. gboard apk android 4.4 4. gboard apk para android 4.4.4