

GUIDE TO COMPLETING CMS 1500 FORM FOR CHW/CHR CLAIMS USING THE SD MEDICAID CLAIMS PORTAL

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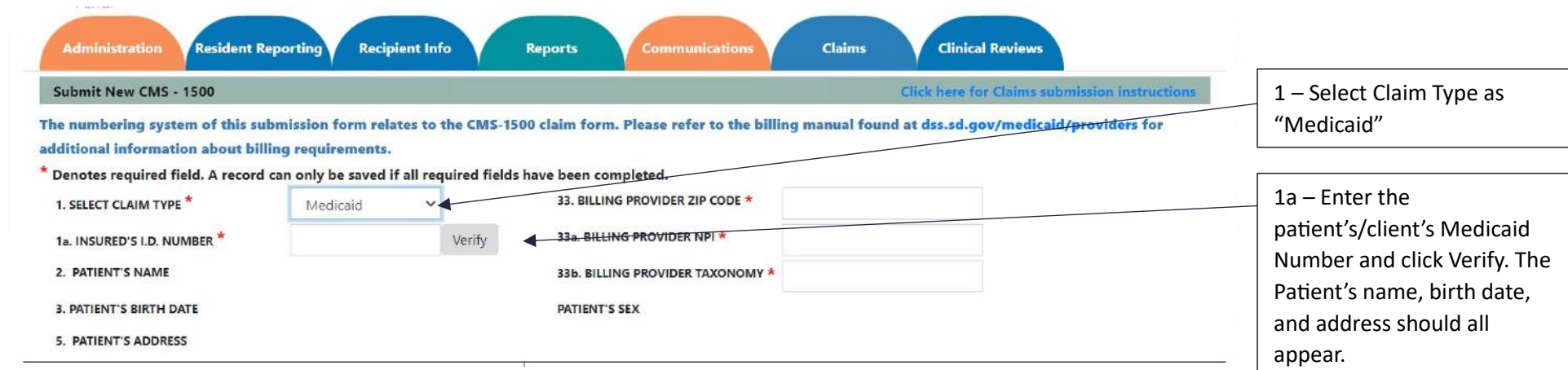
BEGINNING INSTRUCTIONS

This guide is designed for you to fill in information for your specific program that will remain standard throughout in areas that are **blue**, i.e., ZIP: _____ as indicated beginning on page 2 of this guide. Sections marked with a **red** line through them do not need to be filled out to submit a CMS 1500 claim for CHW/CHR Services.



The screenshot shows the Provider Portal navigation bar. At the top right, it says "You are logged in as Provider Admin". Below this, there are links for "User Guide" and "FAQ". The navigation bar consists of several colored buttons: Administration (orange), Resident Reporting (blue), Recipient Info (blue), Reports (teal), Communications (orange), Claims (blue), and Clinical Reviews (blue). A callout box points to the "Claims" button, stating: "To access the CMS 1500 form, click on 'Claims' and select the CMS 1500 option on the dropdown menu."

SUBMITTING CMS 1500 CLAIM



The screenshot shows the "Submit New CMS - 1500" form. At the top, there is a navigation bar with buttons for Administration, Resident Reporting, Recipient Info, Reports, Communications, Claims, and Clinical Reviews. Below the navigation bar, there is a link for "Click here for Claims submission instructions". The form contains several fields and instructions:

- 1. SELECT CLAIM TYPE ***: A dropdown menu with "Medicaid" selected. A callout box points to this field, stating: "1 – Select Claim Type as 'Medicaid'".
- 1a. INSURED'S I.D. NUMBER ***: A text input field. A callout box points to this field, stating: "1a – Enter the patient's/client's Medicaid Number and click Verify. The Patient's name, birth date, and address should all appear."
- Verify**: A button next to the 1a field.
- 33. BILLING PROVIDER ZIP CODE ***: A text input field.
- 33a. BILLING PROVIDER NPI ***: A text input field.
- 33b. BILLING PROVIDER TAXONOMY ***: A text input field.
- PATIENT'S SEX**: A text input field.

At the bottom of the form, there are fields for "2. PATIENT'S NAME", "3. PATIENT'S BIRTH DATE", and "5. PATIENT'S ADDRESS".

Administration
Resident Reporting
Recipient Info
Reports
Communications
Claims
Clinical Reviews

Submit New CMS - 1500
[Click here for Claims submission instructions](#)

The numbering system of this submission form relates to the CMS-1500 claim form. Please refer to the billing manual found at dss.sd.gov/medicaid/providers for additional information about billing requirements.

* Denotes required field. A record can only be saved if all required fields have been completed.

1. SELECT CLAIM TYPE *

Medicaid

33. BILLING PROVIDER ZIP CODE *

1a. INSURED'S I.D. NUMBER *

Verify

33a. BILLING PROVIDER NPI *

2. PATIENT'S NAME

33b. BILLING PROVIDER TAXONOMY *

3. PATIENT'S BIRTH DATE

PATIENT'S SEX

5. PATIENT'S ADDRESS

9. OTHER INSURED'S NAME

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:

9d. OTHER INSURED PLAN NAME OR PROGRAM NAME

a. EMPLOYMENT?

YES

NO

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? *

YES

NO

b. AUTO ACCIDENT?

YES

NO

c. OTHER ACCIDENT?

YES

NO

Save

33 – Enter the ZIP Code registered to your CHW/CHR Program's Type 2 NPI Number (i.e., 57501)
ZIP: _____

33a – Enter your CHW/CHR Program's Type 2 NPI Number as the Billing Provider NPI.
NPI: _____

33b – Enter CHW Taxonomy Code: 172V00000X.

9 – 11d will not need to be changed for any CHW/CHR claims.
Click save.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17b. REFERRING, ORDERING, OR PRESCRIBING NPI																	
19. ADDITIONAL CLAIM INFORMATION 80 Character Limitation																		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<table border="1"> <tr> <td>A</td> <td>Primary</td> <td>B</td> <td>C</td> <td>D</td> <td>E</td> <td>F</td> <td>I</td> </tr> <tr> <td>G</td> <td>H</td> <td>I</td> <td>J</td> <td>K</td> <td>L</td> <td></td> <td></td> </tr> </table>		A	Primary	B	C	D	E	F	I	G	H	I	J	K	L		
A	Primary	B	C	D	E	F	I											
G	H	I	J	K	L													
22. RESUBMISSION CODE	ORIGINAL REFERENCE NO																	
23. PRIOR AUTHORIZATION NUMBER																		

17 – Enter the name of the referring provider – i.e., “Dr. Blanche Devereaux”

17b – Enter the Type 1 NPI number of the referring provider entered in 17.

21 – Enter, at minimum, a Primary Diagnosis Code in box A. Additional secondary diagnosis codes can be added as well in boxes B through L.

Review approved Social Determinants of Health (SDoH) Diagnosis Codes using the Medicaid Diagnosis Lookup Tool - <https://dss.sd.gov/medicaid/providers/diagnosistool.aspx>.

Once diagnosis code(s) have been entered, click save.



The next section provides columns to enter in multiple claims for services provided over multiple dates. The screenshot below shows the columns as displayed in the portal. See page 5 for a detailed description of how to complete this section.

24.	1 *	2	3	4	5	6
A. FROM DOS *	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TO DOS *	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. PLACE OF SERVICE *	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. EMERGENCY	Select ▼	Select ▼	Select ▼	Select ▼	Select ▼	Select ▼
D. PROCEDURES, SERVICES, OR SUPPLIES (CPT or HCPC) *	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PROCEDURE MODIFIER	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC QUANTITY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NDC UNIT OF MEASURE	Select ▼	Select ▼	Select ▼	Select ▼	Select ▼	Select ▼
E. DIAGNOSIS POINTER *	A ▼	A ▼	A ▼	A ▼	A ▼	A ▼
F. \$ CHARGES *	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\$ CONTRACTUAL (CTR)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\$ OTHER PAID	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\$ DED/COINS	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
G. DAYS OR UNITS OF SERVICE *	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
H. EPSDT/FAMILY PLANNING	Select ▼	Select ▼	Select ▼	Select ▼	Select ▼	Select ▼
J. RENDERING PROVIDER NPI	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
RENDERING TAXONOMY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="button" value="✓ Validate"/> <input type="button" value="✗"/>					

24. 1 *

A. FROM DOS *

TO DOS *

B. PLACE OF SERVICE *

C. EMERGENCY

D. PROCEDURES, SERVICES, OR SUPPLIES (CPT or HCPC) *

PROCEDURE MODIFIER

NDC

NDC QUANTITY

NDC UNIT OF MEASURE

E. DIAGNOSIS POINTER *

F. \$ CHARGES *

\$ CONTRACTUAL (CTR)

\$ OTHER PAID

\$ DED/COINS

G. DAYS OR UNITS OF SERVICE *

H. EPSDT/FAMILY PLANNING

J. RENDERING PROVIDER NPI

RENDERING TAXONOMY

✓ Validate ✗

For 24 A. Date of Service (DOS) to DOS will be the date services were provided. Services cannot extend beyond one date per column.

Enter the 2-digit code for the place of service. Refer to the following link for all approved 2-digit codes for place of service: <https://www.cms.gov/medicare/coding-billing/place-of-service->

Enter the appropriate CPT code based on the visit:

98960 – 1 patient 98961 – 2-4 patients 98962 – 5-8 patients

Based on Units of Service entered in Section G, enter charges in section F. The following table includes the calculated amount based on the CPT code used and Units of Service:

CPT Code	1	2	3	4
98960	\$32.43	\$64.86	\$97.29	\$129.72
98961	\$16.22	\$32.44	\$48.66	\$64.88
98962	\$11.35	\$22.70	\$34.05	\$45.40

Based on Units of Service entered in Section G, enter charges in section F. There is a maximum of 4 units per day. The following table includes the calculated amount based on the CPT code used and Units of Service:

Units	1	2	3	4
Time	16-45 min	46-75 min	76-105 min	106 min plus

24J – Enter your CHW/CHR Program’s Type 2 NPI Number as the Rendering Provider NPI.

NPI: _____

24J (second line) – Enter CHW Taxonomy Code: 172V00000X as the rendering taxonomy.

**Once you click validate, you will then need to click “Save” on this section before moving on.

If you are submitting more than one visit for this Medicaid recipient, repeat section 24 in the next column to the right for the next visit.

Update

+ Add

Update

25. FEDERAL TAX I.D.

26. PATIENT'S ACCOUNT NO.

28. \$ TOTAL CHARGE *

29. \$ TOTAL AMOUNT PAID

32. SERVICE FACILITY LOCATION ZIP CODE *

28 – total charges will calculate based on charges entered above.

32 – Enter the ZIP Code registered to your CHW/CHR Program's Type 2 NPI Number (i.e., 57501)

ZIP: _____

Save

Up to 2 attachments with a max of 10 mb each can be uploaded with the following formats. PDF, JPEG and GIF.

+ Add Attachment

Submit

Cancel

Once you click submit, you will need to review and confirm the message at the top of the page to fully submit the claim.

A claim is not considered submitted successfully to Medicaid for review until you receive a message that says: Claim saved successfully. Claim reference number: XXXXXXXXXXXXXXXXXXXX.