Neighborhood Health Plan OF RHODE ISLAND™

Neighborhood Requirements for the CMS-1500 Professional Claim Form

Field Number:	Field Heading:	Required *or* Optional Information?
1	Carrier Type	Optional
1a	Insured's ID Number	Required
2	Patient's Name	Required
3	Patient's Date of Birth and Sex	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient's Relationship to Insured	Required
7	Insured's Address	Optional* ** Per CMS, required when Fields 4, 6, and 11 have data*
8	**Reserved for NUCC Use**	**N/A**
9	Other Insured's Name	Required if Field 11d = Yes
9a	Other Insured's Policy or Group Number	Required if Field 11d = Yes
9b-c	**Reserved for NUCC Use**	**N/A**
9d	Insurance Plan Name or Program Name	Required if Field 11d = Yes
10a	Employment	Required, if applicable
10b	Auto Accident	Required, if applicable
10c	Other Accident	Required, if applicable
10d	**Claim Codes (Designated by NUCC)**	**N/A**
11	Insured's Policy or FECA Number	Required, if applicable* **Required in instances of COB*
11a	Insured's Date of Birth and Sex	Required, if applicable
11b	**Other Claim ID (Designated by NUCC)**	**N/A**
11c	Insurance Plan Name or Program Name	Required, if applicable
11d	Is There Another Health Benefit Plan	Required
12	Patient's or Authorized Person's Signature **and** Date	Required

13	Insured's or Authorized Person's Signature	Required
14	Date of Current Illness, Injury, Pregnancy (LMP) and Qual.	Optional
15	Other Date and Qual.	Optional
16	Dates Patient Unable to Work in Current Occupation	Optional
17	Name of Referring Provider or Other Source	Optional* **Per CMS, this field is required for Medicare beneficiaries*
17a	Referring Provider ID	Optional
17b	Referring Provider NPI	Required if there is data in Field 17
18	Hospitalization Dates Related to Current Services	Optional
19	**Additional Claim Information (Designated by NUCC)**	**N/A**
20	Outside Lab	Optional
21	• Diagnosis or Nature of Illness or Injury – Relate A-L to service line below (24E) • ICD Ind.	Required
22	Resubmission Code/Original Ref. No.	Required ONLY for a corrected/replacement or voided claim
23	Prior Authorization Number	Required, if applicable
24A	Date(s) of Service, From **and** To	Required
24B	Place of Service	Required
24C	Emergency Service (EMG)	Optional
24D	Procedures, Services or Supplies (CPT/HCPCS, Modifiers or NDC numbers)	Required
24E	Diagnosis Pointer	Required
24F	Charges	Required
24G	Days or Units	Required
24H	EPSDT Family Plan	Optional
24I	ID Qualifier	Optional
24J	Rendering Provider ID #	Required
25	Federal Tax ID Number and SSN/EIN	Required

26	Patient's Account Number	Optional
27	Accept Assignment	Required
28	Total Charge	Required* *Continued claims only require a total on the last page
29	Amount Paid	Required, if applicable
30	**Reserved for NUCC Use**	**N/A**
31	Signature of Physician or Supplier **and** Date	Required
32	Service Facility Location Information	Required
32a	Service Facility NPI	Required, if applicable
32b	Other ID	Optional
33	Billing Provider Info & Phone Number	Required
33a	Billing Provider NPI #	Required
33b	Non-NPI ID/Neighborhood provider or vendor number assigned by NHP	Optional