

## WHERE DOES THE NATIONAL PROVIDER IDENTIFIER (NPI) GO ON THE CMS-1500 CLAIM FORM?

Providers continue to have questions on how to complete a CMS-1500 (08/05 version) with the multiple NPI numbers. We have designed this document as one of a series on completing the CMS-1500 claim form.

Key Pieces of information:

- Not all providers are eligible to complete the CMS-1500 claim form
- Completing the form correctly does not guarantee reimbursement from Medicare
- Be sure your provider enrollment and NPPES records are correct
- Sole Practitioners who own a corporation (even if he or she is the only employee) must have a personal type 1 NPI and a corporate type 2 NPI

Field	Information Required	Mandatory Use Date	Date to Leave Blank	Additional Information
17B	Referring/Ordering NPI	5/23/08	N/A	Enter the NPI of the ordering/referring physician.
19	Foot Care: Referring/Ordering NPI	5/23/08	N/A	Enter NPI of the beneficiary's attending physician when a physician providing routine foot care submits claims.
19	Purchased Interpretation: Performing Physician	5/23/08	N/A	Enter the NPI of the physician who is performing a purchased interpretation of a diagnostic test.
24J	Performing Providers NPI	3/1/08	N/A	Enter the performing provider's NPI in the non-shaded portion, if he/she is a member of a group.
32A	Service Facility NPI	3/1/08	N/A	The provider can choose to enter the service facility NPI. This is not a mandatory field.
33A	Group NPI	3/1/08	N/A	Enter the NPI of the billing provider or group. This is a required field.

If you bill electronically, please use the CMS-1500 crosswalk to ANSI X12 4010 located at [http://www.wpsmedicare.com/part\\_b/business/cms1500\\_xw.pdf](http://www.wpsmedicare.com/part_b/business/cms1500_xw.pdf) on the WPS Medicare Website.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/05

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Spouse's SSN) <input type="checkbox"/> CHAMPVA (Member's ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA (BUSINESS) (SSN) <input type="checkbox"/> OTHER (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE (MM   DD   YY)    SEX (M   F)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED (Self   Spouse   Child   Other)					7. INSURED'S ADDRESS (No., Street)									
CITY    STATE					8. PATIENT STATUS (Single   Married   Other)					CITY    STATE									
ZIP CODE    TELEPHONE (Include Area Code) ( ) ( )					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: (Employed   Full-Time Student   Part-Time Student)									
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)									
14. Referring /Ordering Physician's NPI					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM   DD   YY)					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM   TO) (MM   DD   YY)									
17. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM   TO) (MM   DD   YY)					19. RESERVED FOR LOCAL USE									
20. OUTSIDE LAB? (YES   NO)    \$ CHARGES					21. DIAGNOSIS OR NATURE OF ILLNESS (1.   2.)					22. MEDICARE REDUBMISSION CODE    ORIGINAL REF. NO.									
23. PRIORITY AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE (From   To) (MM   DD   YY   MM   DD)					25. FEDERAL TAX I.D. NUMBER    SSN ( ) ( )									
26. BILLING PROVIDER (S) (F. \$ CHARGES   G. CPT OR ICD UNITS   H. ICD-9-CM PROC. CODE   I. ID. QUAL.   J. BILLING PROVIDER ID.#)					27. PATIENT'S ACCOUNT NO.    28. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					29. SERVICE FACILITY LOCATION INFORMATION									
30. BILLING PROVIDER (S) (F. \$ CHARGES   G. CPT OR ICD UNITS   H. ICD-9-CM PROC. CODE   I. ID. QUAL.   J. BILLING PROVIDER ID.#)					31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION									
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**Item 19:**  
 Foot Care: Enter the NPI of the beneficiary's attending physician when a physician providing routine foot care submits claims.  
 Purchased Interpretation: Enter the NPI of the physician who is performing a purchased interpretation of a diagnostic test.

**Item 17B:**  
 Referring /Ordering Physician's NPI

**Item 24J (Non-Shaded):**  
 Performing Provider's NPI: Enter the performing provider's NPI in the non-shaded portion, if they are a member of a group

**Item 32A (Non-Shaded):** this box does not need to be completed  
 Service Facility NPI: The provider can choose to enter the service facility NPI. This is not a mandatory field, and never will be.

**Item 33A (Non-Shaded):**  
 Group NPI: Enter the NPI of the billing provider or group. This is a required field.  
 Sole Practitioner's NPI without a corporation: Enter the performing providers NPI in the non-shaded portion, if he/she is a sole practitioner  
 Sole Practitioner's Corporate NPI: Enter the sole providers corporate NPI (the sole practitioner's individual NPI is entered in 24J)