CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services
A Culture of Caring for 45 Years

CMS 1500 Claim Form Submission Instruction

Providers must use the Center of Medicaid and Medicare Services (CMS) form 1500 when submitting claims to Contra Costa Health Plan (CCHP) for professional services. The data elements are the same for both paper and electronic claims submission. All fields must be completed unless otherwise noted in these instructions.

Field Number	Requirement	Description and Additional Requirements
1	Optional	Type of Insurance
1a	Required	Medi-Cal CIN number or CCHP's member ID
2	Required	Member's name as indicated on the ID card. Requirement for newborn?
3	Required	Member's date of birth and sex
4	If applicable	Not required by Medi-Cal except when billing for a newborn. Enter the mother's name in this field when billing for the newborn
5	Required	Member's complete address and phone number
6	If applicable	Choose only self or child
7	Not required	Insured's address
8	Not required	Patient status
9	Not required	Other insured name
9a	Not required	Other insured's policy or group number
9b	Not required	Other insured's date of birth
9c	Not required	Employer's name or school name
9d	Not required	Insurance plan name or program name
10a	Not required	Patient's condition related to employment
10b	Not required	Patient's condition related to auto accident
10c	Not required	Patient's condition related to other accident
11	Not required	Insured's policy group or FECA number
11a	Not required	Insured's date of birth and sex
11b	Not required	Employer's name or school name
11c	If applicable	Insurance plan name or program name
11d	Required	Is there another health benefit plan?
12	Not required	Signature and date
13	Not required	Insured's or authorized person's signature
14	Required	Date of current illness (first symptom) OR injury (accident) OR pregnancy (last menstrual period)
15	Not required	If patient had same or similar illness, give first date
16	Not required	Dates patient unable to work in current occupation
17	If applicable	Name of referring provider or other source

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17a	If applicable	Medi-Cal provider # or State Medical License number of the referring provider
17b	If applicable	Referring Provider’s NPI number
18	If applicable	Hospitalization admission and discharge dates related to current services
19	If applicable	Reserved for Local Use – use this area for procedures that require additional information, justification or an Emergency Certification Statement
20	If applicable	Outside lab? Check “yes” when diagnostic test was performed by any entity other than the provider billing the service and include the charge
21	Required	Enter all letters and/or numbers for the primary diagnosis, use an ICD-10-CM code for each diagnosis. The first diagnosis listed indicates the primary reason for the service provided
22	Not required	Medicaid Re-submission code
23	Required	Enter prior authorization or referral number
Shaded area above 24	If applicable	Enter NDC/UPN information if applicable
24a	Required	Enter the “from” and “to” dates of service in the MMDDYY format
24b	Required	Enter the place of service code to indicate where the service was rendered
24c	If applicable	EMG – Check box if billing for emergency services and attach required documentation
24d	Required	Enter applicable CPT and/or HCPCS National codes. List modifier if applicable.
24e	Required	Enter the diagnosis code number from box 21 that applies to the procedure code indicated in 24d
24f	Required	Enter the charge for the service in full dollar amount format. If an item is a taxable medical supply, include the applicable state and county sales tax
24g	Required	Enter the number of medical visits or procedures, units of service, units of anesthesia time, etc.
24h	If applicable	Enter code “1” or “2” if the services rendered are related to family planning. Enter code “3” if the services rendered are Child Health and Disability Prevention (CHDP) screening related
24i	If applicable	Enter “X’ if billing for emergency services

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24j	Required	Enter rendering provider's NPI number
25	Required	Enter federal tax ID number
26	Optional	Enter patient's medical record number or account number in this field
27	Not required	Accepted Assignment
28	Required	Enter the total amount of services in dollar and cents. Do not include decimal point (.), do not include dollar sign ($), and do not leave blank
29	If applicable	Enter the amount received from the Other Health Coverage. Enter the full dollar amount and cents.
30	If applicable	Enter the difference between the Total Charges and the Amount Paid in full dollar amount and cents. Do not enter decimal point(.)
31	Required	The claim must be signed and dated by the provider or a representative assigned by the provider
32	Required	Service Facility Location Information – enter the name and address where services were rendered
32a	Required	Enter the NPI of the facility identified in box 32
32b	If applicable	Enter the Medi-Cal provider number of the facility identified in box 32 if applicable
33	Required	Billing Provider Info and Phone – Enter the name, address, and phone number of the billing (pay-to) provider
33a	Required	Enter the billing provider's NPI number
33b	Required	Enter the Medi-Cal provider number of the billing provider