

HOW TO COMPLETE THE HEALTH INSURANCE CLAIM FORM (HCFA-1500) HCFA 1500 Forms Can Be Ordered From The Supply Center 800 - 549 - 5993

The Health Care Financing Administration Health Insurance Claim Form (HCFA-1500) has been designed for claims submitted by physicians and suppliers to the insurance companies, Medicare and other third party payors. The HCFA-1500 claim form has also been adopted by CHAMPUS, and has received the approval of the American Medical Association (AMA) Council on Medical Service. As of May 1, 1992 claim (40-1) will no longer be accepted.

For billing the Medicare program, AMBULANCE PROVIDERS SHOULD CONTINUE TO USE THE HCFA-1491 CLAIM FORM.

Physicians and suppliers are responsible for purchasing their own claim forms, which may be obtained commercially. Forms that are commercially pre-printed are acceptable; however, they must contain the exact information required by HCFA on both the front and back of the claim form.

You may purchase claim forms from The Supply Center by calling 800 - 549 - 5993 or ordering on-line at www.thesupplycenter.com .

The following is information on how to format your HCFA-1500 claim form:

- The form is designed for typewritten characters 10 pitch (pica).
- Use standard dot matrix fonts.
- Character fonts may not be mixed on the same form.
- Italics and script may not be used.
- Old or worn print bands or ribbons should be avoided.
- Use upper case (CAPITALS) letter for all alpha character.
- Do not use dollar signs or decimals in money fields.
- Enter all information on the same horizontal plane.
- Enter all information within the designed field.
- Extraneous data may not be printed, hand-written, or stamped on the form.
- Corrections may be made with correction tape only.
- Corrections may not be handwritten on any data field.
- Pin feed edges are to be removed evenly at side perforations.

BLOCK 8 Check the appropriate box for the patient's marital status and whether employed or a student.

Completing the HCFA-1500 Claim Form

The following is a brief description on completing the HCFA-1500 form.

BLOCK 1 Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

BLOCK 1a Enter the patient's insurance identification number.

BLOCK 2 Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's insurance card.

BLOCK 3 Enter the patient's date of birth and sex.

BLOCK 4 If the patient has health insurance through the spouse's employment or other source, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word SAME may be entered.

BLOCK 5 Enter the patient's permanent mailing address and telephone number. On the first line enter the street address; the second, the city and state; the third, the zip code and phone number.

BLOCK 6 Check the appropriate box for patient's relationship to insured.

BLOCK 7 Enter the insured's address and telephone number except when the address is the same as the patient's - then enter the word "SAME". Complete this block only when block 4 is completed.

BLOCK 9 Show the last name, first name, and middle initial of the insured if it is different from that

shown in Block 2. Otherwise, enter the word "SAME". If you have determined that the patient has no other health insurance coverage, indicate that no other insurance is applicable by writing "N.A." in this block or leave it blank. Otherwise complete this block when the patient has any of the following insurance coverage:

- 1) **Medigap** - A Medigap policy is a policy that meets the statutory definition of a "Medicare supplemental policy" contained in Section 1882(g)(1) of title XVIII of the Social Security Act. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees as well as that offered by a labor organization to members or former members.
- 2) **Employer Retiree Coverage** - This type of coverage refers to a policy that a patient has through a former employer. Typically, when an employee retires, the employer continues his or her coverage under the company's group health plan. When the retiree becomes covered

under Medicare, however, the plan no longer pays primary benefits. Instead, the plan coordinates its benefits with Medicare and essentially serves as a Medicare supplement, subject to the limitations imposed by the specific plan. These policies are generally referred to as "conversion" policies. Even though they do serve to supplement Medicare's benefits, they are not considered to be "Medicare supplemental policies" as defined by Federal law and are, therefore, not subject to the Federal standards for such policies. As noted below, use the designation "EMPLOYER-SUPP" to indicate such coverage in block 9a.

BLOCK 9a Enter the policy and/or group number of the insured's other policy in the following order. For each entry in 9a, there is a corresponding identification in Block 10d. If there is only MEDIGAP coverage to be assigned to a participating physician or supplier enter the insured's policy number here preceded by MEDIGAP In Block 10d enter the identification MG (MEDIGAP). When there is only MEDICAID information to be recorded, enter the patient's MEDICAID number here, preceded by MEDICAID. In Block 10d enter the identifier MCD (MEDICAID). When both MEDIGAP and MEDICAID crossovers are applicable, continue to show the MEDIGAP coverage in the block, and the patient's MEDICAID number in Block 11 and identifying information in block 11 a enter the identification MG/MCD (MEDIGAP/MEDICAID) in Block 10d. In situations in which there is MSP, MEDIGAP and MEDICAID coverage on the same claim, enter the MEDICAID information on an attachment. Enter MSP/MG/MCD (MEDICARE SECONDARY PAYER/

MEDIGAP/MEDICAID) in Block 10d.

If a patient has other insurance, only as supplement to Medicare, by virtue of the patient's or the patient's spouse's former employment, enter the word EMPLOYER-SUPP before the insured's policy or group number in the block. Enter the identification SP (EMPLOYER-SUPP) in Block 10d. If an individual has both a policy primary to Medicare and an EMPLOYER-SUPP policy, MSP information should be entered in Blocks 4, 7 and 11 and the EMPLOYER-SUPP policy number should be entered here preceded by EMPLOYER-SUPP. Enter the identification MSP/SP (MEDICARE SECONDARY PAYER/EMPLOYER-SUPP) in Block 10d and corresponding MSP address on an attachment. If a patient has both MEDIGAP and EMPLOYER-SUPP coverage, enter the MEDIGAP policy number in this block, preceded by MEDIGAP EMPLOYER-SUPP coverages information is entered on an attachment. In Block 10d enter the identification MG/SP (MEDIGAP/EMPLOYER-SUPP).

BLOCK 9b Enter the other insured's date of birth and sex.

BLOCK 9c Enter the claims processing address for the insurance situations as described: if 10d lists only MSP or MSP/MCD, enter the primary insurer's claims processing address in blocks 9c and 9d. If 2 policies are primary to Medicare and there is MEDIGAP, enter 2MSP/MG (2 MEDICARE SECONDARY PAYER/MEDIGAP) in Block 10d, all the MEDIGAP information is listed in Blocks 9, 9a-9d and the address of the first primary insurer and the second primary coverage information is listed on an attachment. If only MG (MEDIGAP) is

entered in Block 10d, use Block 9c for the MEDIGAP insurer's address. If MSP/MG (Medicare Secondary Payer/Medigap) is entered in block 10d, enter the address of the MEDIGAP insurer in Block 9c and the MSP address on an attachment. If MCD (MEDICAID) alone is entered in Block 10d, record MEDICAID information in blocks 9, 9a, and 9b. If MCD/MG (MEDICAID/ MEDIGAP) is listed in block 10d, use Block 9c for the MEDIGAP insurer's address. If SP (EMPLOYER-SUPP) is entered in block 10d, use Block 9c for the EMPLOYER-SUPP address. If MSP/SP (MEDICARE SECONDARY PAYER/EMPLOYER-SUPP) is listed in Block 10d, use Block 9c for the EMPLOYER-SUPP's address and the MSP address is listed on an attachment. If MG/SP (MEDIGAP/EMPLOYER-SUPP) is recorded in Block 10d, use Block 9c for the MEDIGAP address and list identifying information for the EMPLOYER-SUPP on an attachment.

BLOCK 9d Enter the other insured's insurance plan name or the program name (i.e., the patient's health maintenance organization) in a situation which involves anything other than 1 policy primary to Medicare or the other health insurance company. If only 1 MSP coverage exists, this line will be used as the second address line. MSP (MEDICARE SECONDARY PAYER) will be entered in block 10d. Identify a MEDIGAP insurer, by using the carrier prefix, if known. If you are a participating physician or supplier and the patient wants Medicare payment data forwarded to a MEDIGAP insurer, all of the information in Block 9 and its subdivisions must be complete and correct, or the Medicare carrier will not forward the claims information to the MEDIGAP insurer. For

EMPLOYER-SUPP coverage, record the plan name here. Identify EMPLOYER-SUPP insurer by using a carrier prefix, if known. In all cases, Block 10d should be used to correctly identify the nature of the coverage.

If you are a participating physician or supplier and the patient wants Medicare or health insurance company payment data forwarded to another insurer, the following information is required on the attachment:

- Name of the Medigap or other health insurance company
- BLOCKS 10a-10c** Check "YES" or "NO" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in block 24. Enter the State postal code.

BLOCK 10d This block is used to identify the other insurance coverage by category or categories:

KEY MSP =MEDICARE SECONDARY PAYER SP = EMPLOYER-SUPP
 MG = MEDIGAP
 MCD = MEDICAID

- MSP (Blocks 4, 7, 11)
- 21VISP (Blocks 4, 7, 11 and attachment)
- MG (Blocks 9, 9a-9d)
- MSP/MG (MSP-Blocks 4, 7, 11 and attachment; MG- Blocks 9,9a-9d)
- 2MSP/MG (same as 4th bullet)
- MSP/MG/SP (MSP/MG-same as 4th and 5th bullet; SIP on attachment)
- SP (Blocks 9, 9a-9d)
- MSP/SP(MSP- Blocks 4, 7, 11 and attachment; SP-Blocks 9, 9a-9d)
- MG/SP (MG-Blocks 9, 9a-9d; SP attachment)
- MCD (Blocks 9, 9a & 9b)
- MSP/MCD (MSP-Blocks 4,7, 11 with address in Blocks 9c, 9a & 9b)
- MG/MCD (MG-Blocks 9, 9a-9d; MCD-1

company insurer (prefixed by the carrier assigned identification number, if applicable);

- Complete claims processing address (city, state, and zip code) of the Medigap insurer; and
- Patient's Medigap policy number (prefixed by the word "MEDIGAP").

If any of the above information is missing, the Medicare claim or health insurance notices will not be forwarded to the Medigap insurer.

- 1, 11 a)
- MSP/MG/MCD (MSP-Blocks4,7, 11 with address on attachment, MG- Blocks 9, 9a-9d; MCD attachment)

BLOCK 11 If the patient has health insurance primary to Medicare or other health insurance company, through the patient or spouse's employment or other source, list the insured's policy, or group number. For every entry in this block, there should be a corresponding identifier in Block 10d. If MEDICAID and MEDIGAP are identified in 10d, the patient's MEDICAID number is recorded here. If MSR MEDIGAP and MEDICAID occur on the same claim, enter MEDICAID information on an attachment.

The information in this block will be used to report MSP situations where group health plan, spousal insurance, or other circumstances under which Medicare is the secondary payer.

Insurance Primary to Medicare
 Circumstances under which Medicare payment is secondary to other insurance include:

Group Health Plan Coverage
 Working Aged

Disability Large Group Health Plan
End Stage Renal Disease

No Fault and Other Liability

Work-Related Illness/Injury
Workers' Compensation
Black Lung
Veterans Administration

BLOCK 11a Enter the insured's date of birth and sex if different from block 3.

BLOCK 11b Enter employer's name, if applicable.

Data in this field will be used to determine if there is, or is not, primary health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If there is information in blocks 4, 7 and 11, "Yes" must be checked. If "No" is checked, then blocks 4, 7 and 11 would be blank. If "Yes" is checked and blocks 4, 7 and 11 are blank, the claim will be denied. The claim will be denied if this block has not been completed.

BLOCK 11 d Check "YES" or "NO" to indicate if there is, or is not, primary health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If there is information in blocks 4, 7 and 11, "Yes" must be checked. If "No" is checked, then blocks 4, 7 and 11 would be blank. If "Yes" is checked and blocks 4, 7 and 11 are blank, the claim will be denied. The claim will be denied if this block has not been completed.

Note: Since Block 9 will be used strictly for MEDIGAP, SUPPLEMENTAL or MEDICAID crossover claims, dis regard the fine print on the form in this block, which instructs the user to return and complete blocks 9a-9d.

BLOCK 12 Have the patient or his/her authorized representative sign and date this block unless the signature is on file. If the patient's representative signs, the relationship to the patient must be indicated. The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the physician or supplier, if the physician/

mine if Medicare is primary or secondary payer. See block 11 for a description of circumstances under which Medicare is a secondary payer. For every entry in this block, there should be a corresponding identifier in block 10d.

BLOCK 11 c Show the insurance plan or program name. If the primary insurer is a Blue Cross/Blue Shield plan, provide the name of the State or geographic area, e.g., Blue Shield of (State).

supplier accepts assignment.

Signature by Mark – Where an illiterate or physically handicapped enrollee signs by mark (X), a witness must enter his/her name and address next to the mark.

BLOCK 13 The signature in this block authorizes payment of Medigap benefits to the participating physician or supplier if required Medigap information is included in block 9. The patient or his/her authorized representative signs this block, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating physician/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

BLOCK 14 Enter date of current illness, injury or pregnancy. This date is needed to determine the effective date of IVISP coverage. Information in this block is also used to ensure if the x-ray date for chiropractor services is timely.

BLOCK 15 LEAVE THIS BLOCK BLANK.

BLOCK 16 Enter date if patient is unable to work. An entry in this block could indicate employment related insurance coverage.

BLOCK 17 Enter the name of the referring and/or ordering physician or other source if the patient:

- was referred to the performing physician for consultation or treatment;
- was referred to an entity, such as a clinical laboratory, for a service; or
- obtained a physician's order for an item or service from an entity, such as a durable medical equipment supplier.

Physician: The term "physician", when used within the meaning of the States licensing act. It refers to a health care provider legally licensed to practice in the State in which he/she performs such function or action.

A **referring physician** is one who requests an item or service for the patient for which payment may be made under the Medicare or health insurance program. A request might include a consultation with a specialist physician (other than a pathologist who furnishes or personally supervises any test or procedure) or establishment of a plan of care which includes the When the UPIN is omitted or incomplete, and the claim involves multiple referring and/or ordering physicians:

- List the referring and/or ordering physicians' names in block 17 and the UPIN in block 17a. List the procedure code in block 24D in the same order that you listed the referring and/or ordering physicians' name and UPIN;
- The referring and/or ordering physicians' names, I.D. numbers and procedure codes should match in a corresponding order.

If the ordering physician is also the performing physician, the physician must enter his/her UPIN as the ordering physician in block 17a for Medicare claims.

To identify any physicians who do not possess UPINs,

provision of an item or service.

An ordering physician is one who orders non-physician services for the patient, such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, or the technical component of diagnostic tests.

Note: **Medicare requires a UPIN for ordered or referred services for Ambulance, End Stage Renal Disease (ESRD), Magnetic Resonance Imaging, Parenteral/Enteral (PEN, and Physical Therapy services.**

BLOCK 17a Effective for dates of service January 1, 1992 and after, a physician or supplier that bills Medicare for a service or item must show the name and UPIN (or the appropriate surrogate number) of the ordering/referring physician on the claim form if that service or item is the result of an order or referral from a physician.

you should use a specified "surrogate number" and the physician's name and address on claims when the referring and/or ordering physician does not have a UPIN. Claims received with surrogate numbers will be tracked and possibly audited.

There are several circumstances under which a physician service claim will not have a UPIN, but should not be rejected:

1. **Interns and Residents** - UPINs for interns and residents will be issued sometime in calendar year 1992. In the meantime, billers are to use the six (6) character surrogate UPIN: RES000 for residents and INT000 for interns. If a physician leaves the hospital and has not yet received a UPIN, the physician may continue to use the surrogate used in

the hospital until a UPIN is assigned. Once the physician has entered into private practice, the hospital surrogate can be used for a minimum of thirty days.

2. **Physicians with Military, Veterans Administration, Public Health Service and Bureau of Indian Affairs** - Physicians serving with these Federal agencies should obtain a UPIN if they provide or refer services to Medicare beneficiaries. For the time being, use the following surrogate UPINs:

- VAD000 - Physicians serving on active duty in the military of the United States and those employed by the Veterans Administration.
- BIA000 - Physicians serving in the Indian Health Service.
- PHS000 - Physicians serving in the Public Health Service.

3. Physicians who have retired from practice prior to issuance of UPINs and who do not charge for services to a Medicare patient, but may refer or order services for such patients;

- RET000 Physicians who are retired.

4. **"Special Use" UPIN** - Situations may evolve that do not fall within the above categories. Use the surrogate OTH000 if:

BLOCK 20 Complete this block to indicate billing for clinical diagnostic laboratory tests. Enter the purchase price under charges if the "YES" box is checked. A "yes" check indicates that the lab test was performed outside of the physician's office. A "no" check indicates that no purchased tests are included on the claim. When the "yes" is annotated, block 32 must show the name, address and carrier assigned provider

- the ordering and performing physician are one in the same, or
- the ordering and performing physician has not been assigned a UPIN and does not qualify for any of the other surrogates listed above.

5. **Self Referral** - There are several kinds of services that may be self-referred, i.e., the patient obtains the service without an attending physician's referral, the patient is referred to a physician by a pharmacist, physical therapist or some other person or entity not meeting the Medicare statutory definition of a physician.

- SLF000 Self referral

Also use SLF000 for ambulance services that were ordered by the patient or via 911.

The carriers will monitor the use of all surrogate UPINs to ensure that physicians, providers and suppliers are complying with the ordering referring identification requirement.

BLOCK 18 Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization

BLOCK 19 Enter the date the patient was last seen and the UPIN of his/her attending physician for a claim billed by an independent physical therapist or podiatrist.

identification number (PIN) of the clinical laboratory that performed the service.

When tests are personally performed, check "NO" in block 20 and include the statement "No purchased services on this claim."

BLOCK 21 Describe the nature of the illness or injury treated. ICD-9-CM diagnosis codes

MUST be used by physicians, to the highest level of specificity. Use up to four codes by order of severity. Enter the appropriate diagnosis code for screening mammography or screening pap smears.

BLOCK 22 LEAVE THIS BLOCK BLANK.

BLOCK 23 Enter the Professional Review Organization (PRO) prior authorization number for certain surgical procedures and for an assistant at cataract surgery.

BLOCK 24a Enter the month, day and year for each procedure, service or supply. If "From" and "To" dates are shown here for a series of identical services, the corresponding number of services should appear in block 24G.

BLOCK 24b Enter the appropriate place of service codes from the ~~list below~~ **list below** services are provided on an ambulatory basis.

Office (11)

Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

Patient's Home (12)

Location, other than a hospital or other facility, where the patient receives care in a private residence.

Inpatient Hospital (21)

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a

(both surgical and non-surgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

Outpatient Hospital (22)

A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Emergency Room - Hospital (23)

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

Ambulatory Surgical Center (24)

A freestanding facility, other than a physician's office, where surgical and ambulatory services are provided on an ambulatory basis.

Birthing Center (25)

A facility other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of new born infants.

Military Treatment Facility (26)

A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (IVITF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

Skilled Nursing Facility (31)

hospital.

Nursing Facility (32)

A facility which primarily provides to residents skilled nursing care and related

services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

Custodial Care Facility (33)

A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

Hospice (34)

A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

Ambulance-Land (41)

A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

Ambulance-Air or Water (42)

An air or water vehicle specifically designed, equipped and staffed for live saving and transporting the sick or injured.

Inpatient Psychiatric Facility (51)

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Psychiatric Facility Partial Hospitalization (52)

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.

Community Mental Health Center (53)

A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.

Intermediate Care Facility-Mentally Retarded (54)

A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF

Residential Substance Abuse Treatment Facility (55)

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Psychiatric Residential Treatment Center (56)

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

Comprehensive Inpatient Rehabilitation Facility (61)

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

End Stage Renal Disease Treatment Facility (65)

A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Rural Health Clinic (72)

A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

Independent Laboratory (81)

A laboratory certified to perform diagnostic and/or clinical test independent of an institution or a physician's office.

Other Unlisted Facility (99)

Other service facilities not identified above.

With the exception of hospital inpatients, the place of service for laboratory tests will be based on where "drawn" instead of where the test is actually performed.

Suppliers using central billing operations must identify the office or sales/rental outlet location from which the services were furnished (or equipment rented or purchased) in this block. Use the place of service code as defined above. The carrier receiving the claim develops the location of the sale, rental or other services if this information is not shown.

BLOCK 24C LEAVE THIS BLOCK BLANK.

BLOCK 24D Enter the procedures, services, or supplies using the HCFA Common Procedure Coding System (HCPCS). Also show, when applicable, HCPCS modifiers with the HCPCS code.

When anesthesia codes are billed, be sure to indicate the elapsed time (minutes) in Block 24G. Convert hours into minutes and enter the total minutes required for this procedure.

State or Local Public Health Clinic (71)

For diagnostic pap smears and related medically necessary services performed on or after July 1, 1990, use one of the following HCPCS codes:

- **88150** - Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou), up to three smears, screening by technician under physician supervision; or
- **88151** - Cytopathology, smears, cervical or vaginal (e.g. Papanicolaou), up to three smears, requiring interpretation by a physician.

For screening pap smears and related medically necessary services performed on or after July 1, 1990, use one of the following HCPCS codes:

- Q0060 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, screening by technician under physician supervision; or
- Q0061 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by a physician.

For screening mammography claims, use code 76092 with the appropriate modifiers.

BLOCK 24E Enter the diagnosis code reference number as shown in block 21, to relate the date of service and the procedures performed to the appropriate diagnosis. Show a maximum of 4 diagnosis code reference numbers (i.e., 1, 2, 3, and 4 ICD-9-CM codes). If multiple services are being performed, enter the diagnosis codes warranting each service.

BLOCK 24F Enter the charge for each listed service. If anatomical laboratory services were performed outside the physician's office, each laboratory

service must be listed with the laboratory's actual charge and the physician's charge given. If more than one laboratory was used, or if the physician performed some laboratory services and some were sent out, the identification of the laboratory, with each laboratory service it performed, Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

- For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in block 24G, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen was delivered during the rental month, the unit entry "011 indicating the nearest 50 cubic foot increment is entered in block 24G.
- For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen was delivered during the applicable rental month billed, the unit entry "06" is entered in block 24G.
- For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or one liquid pound,

must be shown.

BLOCK 24G Enter the days or units in this block. This field is most commonly used for multiple visits, units of supplies, anesthesia time (minutes), or oxygen volume.

respectively.

BLOCK 24H LEAVE THIS BLOCK BLANK.

BLOCK 24I Check this block only if the service was rendered in a hospital emergency room. If this block is checked, the place of service code in block 24B should matc