

CMS-1500 Preparation Checklist

Verify all required fields before submitting a CMS-1500 professional claim form

The CMS-1500 (02/12) is the standard paper claim form for professional services. Use this checklist before each submission — paper or electronic (837P). Check payer-specific field requirements before submitting.

PATIENT & INSURED INFORMATION (BOXES 1–13)

- Box 1 — Insurance type box checked (Medicare, Medicaid, TRICARE, CHAMPVA, Group, FECA, Other)
- Box 1a — Insured's ID number: matches member ID exactly (no spaces or dashes unless payer requires)
- Box 2 — Patient's last name, first name, middle initial (LAST, FIRST, MI format)
- Box 3 — Patient DOB (MM/DD/YYYY) and sex selected
- Box 4 — Insured's name (if different from patient; same format as Box 2)
- Box 5 — Patient address, city, state, ZIP; phone (with area code)
- Box 6 — Patient relationship to insured selected (Self, Spouse, Child, Other)
- Box 7 — Insured's address (complete if different from patient; leave blank if same)
- Box 9 — Other insured's name (complete if COB applies)
- Box 9a — Other insured's policy or group number
- Box 9d — Insurance plan or program name (other insured)
- Box 10a–c — Is condition related to employment / auto accident / other accident? Box checked Yes or No
- Box 10d — Claim codes (reserved; check payer requirement)
- Box 11 — Insured's policy group or FECA number
- Box 11a — Insured's DOB and sex
- Box 11b — Other claim ID (if required by payer)
- Box 11c — Insurance plan or program name
- Box 11d — Is there another health benefit plan? Yes/No checked
- Box 12 — Patient or authorized person signature; 'Signature on File' acceptable
- Box 13 — Insured or authorized person signature / Signature on File

PHYSICIAN/SUPPLIER INFORMATION (BOXES 14–33)

- Box 14 — Date of current illness / LMP / injury (if applicable to claim type)
- Box 15 — Other date (if applicable — check payer requirements)
- Box 16 — Dates patient unable to work (if applicable)
- Box 17 — Name of referring physician or other source (required for referred services)
- Box 17a — Other ID of referring provider (check payer; often left blank)
- Box 17b — NPI of referring provider (required when Box 17 is completed)
- Box 18 — Hospitalization dates (complete for inpatient admissions)
- Box 19 — Additional claim information (check payer-specific requirements)
- Box 20 — Outside lab: Yes or No checked; charges if Yes
- Box 21 — ICD indicator set to '0' (ICD-10); up to 12 diagnosis codes in A–L

- Box 21 — Primary diagnosis in field A; related codes in B–L
- Box 22 — Medicaid resubmission code and original claim number (resubmissions only)
- Box 23 — Prior authorization number (if required and obtained)
- Box 24A — Dates of service (From/To); single date for each unique line
- Box 24B — Place of service code (11=office, 21=inpatient, 02=telehealth, 10=home, etc.)
- Box 24C — Emergency indicator Y/N (complete only when applicable)
- Box 24D — CPT/HCPCS procedure code; modifier(s) if applicable
- Box 24E — Diagnosis pointer(s) — link each line to correct Box 21 letter(s)
- Box 24F — Charge amount for each service line
- Box 24G — Days or units
- Box 24H — EPSDT/family plan (Medicaid only)
- Box 24I / 24J — Rendering provider NPI in Box 24J (shaded area if group, unshaded if individual)
- Box 25 — Federal Tax ID (EIN preferred); type checked
- Box 26 — Patient's account number (your internal account number)
- Box 27 — Accept assignment: Yes (PAR providers); check payer requirement
- Box 28 — Total charge (sum of all 24F lines)
- Box 29 — Amount paid by patient (e.g., copay collected at visit)
- Box 31 — Physician's/supplier's signature and date
- Box 32 — Service facility location name and address (if different from billing address)
- Box 32a — Service facility NPI
- Box 32b — Service facility other ID (if required by payer)
- Box 33 — Billing provider name, address, phone number
- Box 33a — Billing provider NPI
- Box 33b — Billing provider other ID (if required by payer)

FINAL VERIFICATION

- All CPT codes valid for the date of service (verify current code year)
- ICD-10 codes at highest specificity (no unspecified codes where specific is available)
- Modifier(s) supported by documentation in the medical record
- All NPI numbers verified (rendering, billing, referring if applicable)
- Claim frequency code: 1=Original, 7=Corrected, 8=Void
- Payer-specific field requirements verified before submission
- Claim reviewed by a second set of eyes before submission (recommended for high-value claims)