

Clean Claim Checklist

Pre-submission checklist to reduce denials and rework on CMS-1500 claims

CLAIM HEADER — BOXES 1-13

- Box 1 — Insurance type checked (Medicare, Medicaid, TRICARE, CHAMPVA, Group, FECA, Other)
- Box 1a — Insured's ID number matches the member ID on the insurance card exactly
- Box 2 — Patient's name (Last, First, Middle Initial) — matches payer records
- Box 3 — Patient's date of birth and sex completed
- Box 4 — Insured's name completed (if different from patient)
- Box 5 — Patient's address completed (street, city, state, ZIP)
- Box 6 — Patient's relationship to insured checked
- Box 7 — Insured's address completed (if different from patient)
- Box 8 — Reserved for NUCC use (leave blank unless payer requires)
- Box 9a-d — Other insured's information completed if COB applies
- Box 10a-c — Condition related to (employment / auto accident / other accident) checked
- Box 11 — Insured's policy group or FECA number completed
- Box 11a — Insured's date of birth and sex completed
- Box 11b — Other claim ID (designated by NUCC) — complete if applicable
- Box 11c — Insurance plan or program name completed
- Box 11d — Is there another health benefit plan? Box checked Yes or No
- Box 12 — Patient's or authorized person's signature on file / signed
- Box 13 — Insured's or authorized person's signature on file / signed

DIAGNOSIS & SERVICE INFORMATION — BOXES 14-24

- Box 14 — Date of current illness / injury / pregnancy (if applicable)
- Box 17 — Referring provider name and NPI (required for some payers and services)
- Box 18 — Hospitalization dates (if applicable — inpatient only)
- Box 19 — Additional claim information (check payer-specific requirements)
- Box 20 — Outside lab: Yes/No checked; charges entered if Yes
- Box 21 — ICD-10 diagnosis codes entered (A-L); ICD indicator set to '0' for ICD-10
- Box 21 — Primary diagnosis code in field A; additional codes in B-L as applicable
- Box 22 — Medicaid resubmission code and original claim number (if resubmission)
- Box 23 — Prior authorization number entered (if auth was obtained)

LINE ITEMS — BOX 24 (A THROUGH J)

- Box 24A — Dates of service: From and To dates completed for each line
- Box 24B — Place of service code correct for the setting (11=office, 02=telehealth, etc.)
- Box 24C — EMG indicator (Y/N) — complete only if emergency

- Box 24D — CPT/HCPCS code correct and current; modifier(s) added if required
- Box 24D — Modifiers appropriate for the service and payer (not stacked unnecessarily)
- Box 24E — Diagnosis pointer(s) link each line to the correct ICD-10 from Box 21
- Box 24F — Charges: fee entered for each line; matches fee schedule
- Box 24G — Days or units correct (1 unit unless service requires more)
- Box 24H — EPSDT/Family plan indicator (Medicaid only, if applicable)
- Box 24I — ID qualifier (if NPI alternative used — usually blank)
- Box 24J — Rendering provider NPI entered on each line

PROVIDER & PAYER INFORMATION — BOXES 25–33

- Box 25 — Federal Tax ID (EIN or SSN) and type checked
- Box 26 — Patient account number (your internal account/chart number)
- Box 27 — Accept assignment: Yes checked for participating providers
- Box 28 — Total charge: sum of all Box 24F line charges
- Box 29 — Amount paid by patient (copay/coinsurance collected at time of service, if any)
- Box 31 — Provider signature and date (or 'Signature on File')
- Box 32 — Service facility location name and address (if different from billing address)
- Box 32a — Service facility NPI
- Box 33 — Billing provider name, address, phone
- Box 33a — Billing provider NPI
- Box 33b — Other ID number (if required by payer)

FINAL PRE-SUBMISSION REVIEW

- All dates of service fall within the patient's active coverage period
- NPI used is correct for the service type (individual vs. group/facility)
- Claim frequency code is correct (1=original, 7=corrected, 8=void)
- No diagnosis codes with invalid characters or non-specific codes where specific is required
- CPT codes are valid for the DOS (check for code expiration / new codes)
- Modifier use is supported by documentation in the medical record
- Payer-specific requirements verified (check payer policy before submission)
- Clearinghouse pre-edit passed with no errors or warnings

Notes / Payer-Specific Requirements: