DevotedHealth

CMS-1500 Paper Claims Requirements

This guide describes how to complete a paper CMS-1500 claim form. Devoted Health requires that CMS-1500 paper claim forms be submitted with the (Required or If applicable) fields, to avoid returned and/or rejected claims that will be sent back to the providers for correction or resubmission.

It is important that providers submit claims to Devoted Health on the standard red and white version of the CMS-1500 form to ensure timely and accurate processing. We do not accept black and white and/ or copied cMS-1500 forms, along with any handwritten data elements or information.

Additional updates are available in the Provider Manual or on our website at www.Devoted.com . For further assistance regarding paper claim submission, please contact Devoted Health Provider Service Call Center at 1-877-762-3515.

Field Location	Field Name	Required, Optional, or If applicable
1	Type of Insurance	Required
1a.	Insured's I.D. Number	Required
2	Patient's Name	Required
3	Patient's Birth Date	Required
4	Insured's Name	Optional
5	Patient's Address	Required
6	Patient's Relationship to Insured	Required
7	Insured's Address	Optional
8	Patient Status	Optional
9	Other Insured's Name	If applicable
9a.	Other Insured's Policy or Group Number	If applicable
9b.	Other Insured's Date of Birth	If applicable
9c.	Employer's Name or School Name	If applicable
9d.	Insurance Plan Name of Program Name	If applicable
10	Is Patient's Condition Related to	If applicable

10a.	Employment? Yes/No	If applicable
10b.	Auto Accident Yes/No	If applicable
10c.	Other Accident? Yes/No	If applicable
10d.	Reserved For Local Use	If applicable
11	Insured's Policy Group or FECA Number	If applicable
11a.	Insured's Date of Birth	If applicable
11b.	Employer's Name or School Name	If applicable
11c.	Insurance Plan Name or Program Name	If applicable
11d.	Is there another Health Plan Benefit? Yes/No	If applicable
12	Patient's or Authorization Person's Signature and Date	Required
13	Insured's or Authorization Person's Signature	Required
14	Date of Current Illness, Injury, or Pregnancy (LMP)	If applicable
15	If patient has had same or similar illness. Give first date	Optional
16	Dates patient unable to work in current occupation	If applicable
17	Name of referring provider or other source	If applicable
17a. & b.	NPI - Enter referring provider's NPI number	If applicable
18	Hospitalization dates related to current services	If applicable
19	Reserved for local use	Optional
20	Outside Lab?	If applicable
21(A - L)	Diagnosis or nature of illness or injury	Required
22	Medicaid Resubmission Code/Original Ref. No.	Required
23	Prior Authorization Number	If applicable

24A.	Date(s) of Service	Required
24B.	Place of Service	Required
24C.	EMG (Emergency Indicator)	If applicable
24D.	Procedures, Services, or Supplies - (CPT/HCPCS and Modifier)	Required NOTE: Modifier if applicable
24E.	Diagnosis Pointer	Required
24F.	Charges	Required
24G	Days, Units, Minutes	Required
24H.	EPSDT Family Plan	If applicable
24I.	ID Qualifier	If applicable
24J.	Rendering Provider ID #/NPI	Required
25	Federal Tax I.D. Number (SSN/EIN)	Required
26	Patient's Account No.	Required
27	Accept Assignments? Yes/No	Required
28	Total Charge	Required
29	Amount Paid	If applicable
30	Balance Due	If applicable
31	Signature of Physician or Supplier (Signature/Date)	Required
32	Service Facility Location Information	If applicable
32a.	Service Facility Location NPI	If applicable
32b.	Service Facility Location Provider ID Number	If applicable
33	Billing Provider Info & Ph #	Required
33a.	Billing Provider NPI	Required
33b.	Billing Provider ID Number	Required