

**CMS 1500 (08/05) INSTRUCTIONS FOR AMBULANCE AND AIR  
AMBULANCE SERVICES**

**You must write “AMB” at the top center of the claim form!**

<b>Locator #</b>	<b>Description</b>	<b>Instructions</b>	<b>Alerts</b>
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an “X” in the box marked Medicaid (Medicaid #).	<b>You must write “AMB” at the top center of the Louisiana Medicaid claim form.</b>
1a	Insured’s I.D. Number	<b>Required</b> – Enter the recipient’s 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.  <b>NOTE:</b> The recipients’ 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the recipient’s name in Block 2.	<b>Formerly entered in Block 4 of the Unisys 105 Claim Form.</b>
2	Patient’s Name	<b>Required</b> – Enter the recipient’s last name, first name, middle initial.	<b>Formerly entered in Blocks 1, 2, and 3 of the Unisys 105 Claim Form.</b>
3	Patient’s Birth Date  Sex	<b>Situational</b> – Enter the recipient’s date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).  Enter an “X” in the appropriate box to show the sex of the recipient.	<b>Formerly entered in Blocks 6 and 7 of the Unisys 105 Claim Form.</b>
4	Insured’s Name	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient’s Address	<b>Optional</b> – Print the recipient’s permanent address.	<b>Formerly entered in Block 5 of the Unisys 105 Claim Form.</b>

Locator #	Description	Instructions	Alerts
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	Patient Status	<b>Optional.</b>	
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<p><b>Situational</b> – If recipient has no other coverage, leave blank.</p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block (the carrier code list can be found at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under the <b>Forms/Files</b> link).</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	<b>The TPL Carrier Code was formerly entered in Block 12 of the Unisys 105 Claim Form.</b>
9b	Other Insured's Date of Birth  Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
9c	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	<b>Situational</b> – Complete if appropriate or leave blank.	<b>Formerly entered in Block 11 of the Unisys 105 Claim Form.</b>
11	Insured's Policy Group or FECA Number	<b>Situational</b> – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth  Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	Employer's Name or School Name	<b>Situational</b> – Complete if appropriate or leave blank.	

<b>Locator #</b>	<b>Description</b>	<b>Instructions</b>	<b>Alerts</b>
11c	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	<b>Situational</b> – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	<b>Optional.</b>	
15	If Patient Has Had Same or Similar Illness Give First Date	<b>Optional.</b>	
16	Dates Patient Unable to Work in Current Occupation	<b>Optional.</b>	
17	Name of Referring Provider or Other Source	Leave blank.	
17a	Unlabelled	<b>Situational</b> – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is <b>required</b> to be entered.	<b>The PCP's 7-digit referral authorization number must be entered in block 17a.</b>
17b	NPI	<b>Optional.</b>	<b>The revised form accommodates the entry of the referring provider's NPI. Enter the CommunityCARE PCP's NPI.</b>

Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	Leave blank.	
19	Reserved for Local Use	Leave blank.	
20	Outside Lab?	Leave blank.	
21	Diagnosis or Nature of Illness or Injury	<b>Required</b> -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	<b>Formerly entered in Block 13 of the Unisys 105 Claim Form.</b>
22	Medicaid Resubmission Code	<p><b>Situational.</b> If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u>  01 = Third Party Liability Recovery  02 = Provider Correction  03 = Fiscal Agent Error  90 = State Office Use Only – Recovery  99 = Other</p> <p><u>Voids</u>  10 = Claim Paid for Wrong Recipient  11 = Claim Paid for Wrong Provider  00 = Other</p>	<b>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</b>
23	Prior Authorization Number	<p><b>Situational</b> – Complete if appropriate or leave blank.</p> <p>If the services being billed are Air Ambulance and must be Prior Authorized, the PA number is <b>required</b> to be entered.</p>	<b>Air Ambulance Services must be Prior Authorized and the 9-digit PA number must be entered in this field.</b>

Locator #	Description	Instructions	Alerts
24	Supplemental Information	Leave blank.	
24A	Date(s) of Service	<b>Required</b> -- Enter the date of service for each procedure.  Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	<b>Formerly entered in Block 17A of the Unisys 105 Claim Form.</b>
24B	Place of Service	Leave blank.	
24C	EMG	<b>Required</b> – Enter type of service:  9 or Y – Emergency 3 or N – Non-emergency	<b>Formerly entered in Block 17B of the Unisys 105 Claim Form.</b>  <b>Providers may enter a 9 or Y for emergency services and a 3 or N for non-emergency services. Failure to enter an indicator will default to non-emergency.</b>
24D	Procedures, Services, or Supplies	<b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter the appropriate modifier if applicable.	<b>Formerly entered in Block 17C of the Unisys 105 Claim Form.</b>
24E	Diagnosis Pointer	Leave blank.	
24F	\$Charges	<b>Required</b> -- Enter usual and customary charges for the service rendered.	<b>Formerly entered in Block 17F of the Unisys 105 Claim Form.</b>

Locator #	Description	Instructions	Alerts
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D or the one-way mileage as applicable.	<b>Formerly entered in Block 17E of the Unisys 105 Claim Form.</b>  <b>Ensure that the appropriate units are entered for the service (i.e., 1 unit for transport and the number of miles for mileage).</b>
24H	EPSDT Family Plan	Leave blank.	
24I	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	<b>The revised form accommodates the entry of I.D. Qual.</b>
24J	Rendering Provider I.D. #	Leave blank.	
25	Federal Tax I.D. Number	<b>Optional.</b>	
26	Patient's Account No.	<b>Situational</b> – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	<b>Formerly entered in Block 10 of the Unisys 105 Claim Form.</b>
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	<b>Formerly entered in Block 17F of the Unisys 105 Claim Form.</b>
29	Amount Paid	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor. Enter '0' if the third party did not pay.  If TPL does not apply to the claim, leave blank.	<b>Formerly entered in Block 17G of the Unisys 105 Claim Form.</b>

Locator #	Description	Instructions	Alerts
30	Balance Due	<b>Situational</b> – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Required</b> -- The claim form <b>MUST</b> be signed. The practitioner or the practitioner’s authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed.  <b>Required</b> -- Enter the date of the signature.	<b>Formerly entered in Block 23 of the Unisys 105 Claim Form.</b>
32	Service Facility Location Information	<b>Required</b> – Enter: <ul style="list-style-type: none"> <li>• The complete address of origin of services.</li> <li>• The time of departure from origin.</li> <li>• The complete address of destination.</li> <li>• The time of arrival at destination.</li> </ul>	<b>Enter the complete address of the origin of services, the time of departure from origin (including a.m. or p.m.), the complete address of destination, and the time of arrival at destination (including a.m. or p.m.)</b>
32a	NPI	Leave blank.	
32b	Unlabelled	Leave blank.	
33	Billing Provider Info & Ph #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	<b>Formerly entered in Block 8 of the Unisys 105 Claim Form.</b>
33a	NPI	<b>Optional.</b>	<b>The revised form accommodates the entry of the Billing Provider’s NPI.</b>

Locator #	Description	Instructions	Alerts
33b	Unlabelled	<b>Required</b> – Enter the billing provider’s 7-digit Medicaid ID number.	<b>Formerly entered in Block 9 of the Unisys 105 Claim Form. The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.</b>

# SAMPLE AMBULANCE CLAIM FORM

**1500**

## AMB

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																																																																						
1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567891234</b>																																																																																																																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Adalam, Mary</b>						3. PATIENT'S BIRTH DATE <b>06   11   89</b> M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																													
5. PATIENT'S ADDRESS (No., Street)  CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) _____						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)  CITY _____ STATE _____ ZIP CODE _____ TELEPHONE (Include Area Code) _____																																																																																																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM DD YY _____ SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME _____ c. INSURANCE PLAN NAME OR PROGRAM NAME _____ d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, return to and complete item 9 a-d.</i>																																																																																																													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																																																																																																																
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY _____				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY _____				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY _____ TO MM DD YY _____																																																																																																														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY _____ TO MM DD YY _____				19. RESERVED FOR LOCAL USE																																																																																																														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>458.9</b>						20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																																																																																																																
22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						23. PRIOR AUTHORIZATION NUMBER <b>987654321</b>																																																																																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">1</th> <th colspan="2">A. DATE(S) OF SERVICE</th> <th rowspan="2">B. PLACE OF SERVICE</th> <th rowspan="2">C. EMG</th> <th colspan="2">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th rowspan="2">E. DIAGNOSIS POINTER</th> <th rowspan="2">F. \$ CHARGES</th> <th rowspan="2">G. DENTS UNITS</th> <th rowspan="2">H. SPORT Family Plan</th> <th rowspan="2">I. ID. QUAL</th> <th rowspan="2">J. RENDERING PROVIDER ID #</th> </tr> <tr> <th>From MM DD YY</th> <th>To MM DD YY</th> <th>CPT/HCPCS</th> <th>MODIFIER</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>04</td><td>16</td><td>09</td> <td>04</td><td>16</td><td>09</td> <td>9</td> <td>A0431</td> <td>SH</td> <td></td> <td></td> <td>6100.00</td> <td>1</td> <td>NPI</td> </tr> <tr> <td>2</td> <td>04</td><td>16</td><td>09</td> <td>04</td><td>16</td><td>09</td> <td>9</td> <td>A0436</td> <td>SH</td> <td></td> <td></td> <td>2688.00</td> <td>32</td> <td>NPI</td> </tr> <tr> <td>3</td> <td>04</td><td>16</td><td>09</td> <td>04</td><td>16</td><td>09</td> <td>9</td> <td>A0398</td> <td>SH</td> <td></td> <td></td> <td>109.00</td> <td>1</td> <td>NPI</td> </tr> <tr> <td>4</td> <td>04</td><td>16</td><td>09</td> <td>04</td><td>16</td><td>09</td> <td>9</td> <td>A0394</td> <td>SH</td> <td></td> <td></td> <td>108.00</td> <td>1</td> <td>NPI</td> </tr> <tr> <td>5</td> <td>04</td><td>16</td><td>09</td> <td>04</td><td>16</td><td>09</td> <td>9</td> <td>A0422</td> <td>SH</td> <td></td> <td></td> <td>99.00</td> <td>1</td> <td>NPI</td> </tr> <tr> <td>6</td> <td></td><td></td><td></td> <td></td><td></td><td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> </tbody> </table>												1	A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DENTS UNITS	H. SPORT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID #	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER	1	04	16	09	04	16	09	9	A0431	SH			6100.00	1	NPI	2	04	16	09	04	16	09	9	A0436	SH			2688.00	32	NPI	3	04	16	09	04	16	09	9	A0398	SH			109.00	1	NPI	4	04	16	09	04	16	09	9	A0394	SH			108.00	1	NPI	5	04	16	09	04	16	09	9	A0422	SH			99.00	1	NPI	6														NPI
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25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO. <b>12345</b>			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ <b>9104.00</b>		29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ _____																																																																																																										
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  <b>Ima Biller</b> <b>5/1/09</b>						32. SERVICE FACILITY LOCATION INFORMATION <b>123 Any Street 9:00 a.m.</b> <b>Anywhere, LA</b> <b>321 Nowhere Rd.</b> <b>Anywhere, LA 9:30 a.m.</b>			33. BILLING PROVIDER INFO & PH # (264) 555-0000 <b>ABC Ambulance Service</b> <b>123 Smiley St.</b> <b>Sunny, LA 70000</b>																																																																																																													
SIGNED _____ DATE _____						a. NPI _____			b. _____		a. <b>1357901357</b>		b. <b>1999999</b>																																																																																																									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION