

Basic information required to complete claims submissions using a CMS 1500

(Some payers or specific programs may require additional fields to be completed.)

- 1a: **Insured's I.D. Number:** Clients' health plan ID/member number
- 2: **Patient's Name:** Name as registered with the health plan
- 3: **Patient's birthdate and sex**
- 4: **Insured's Name:** Name of the person who holds the policy (i.e., the subscriber)
- 5: **Patient's address**
- 6: **Patient relationship to insured**
- 7: **Insured's address:** Address of the policy holder, may be different than the patient's address (field 5)
- 11: **Insured's policy group number or FECA number:** Frequently but not always required.
- 17: **Referring provider:** Medicare requires the name of the referring physician (MD, DO). Individual patient policies or general payer policies could require referrals from physicians or other qualified providers for payment or for other reasons (e.g., a regulation).
- 17b: **Referring providers' National Provider Identifier (NPI):** Use the NPPES [NPI Registry](#) if you do not have the referring provider's NPI.
- 21: **Diagnosis or nature of illness or injury:**
Use fields A-L to provide the ICD10-CM code(s) that correspond with the patient's/client's conditions(s) provided by a physician or other provider qualified to provide medical diagnoses. Provide only the IC10-10 code(s) that are covered under the individual patient's policy. Appropriate Z codes that are covered under an individual's policy are also included in field 21 (e.g., Z codes reflecting BMI or dietary screening and surveillance).
- 24A: **Date(s) of service:** Include the date(s) of service for one or multiple visits.
- 24B: **Place of service:** Include the [place of service code](#) that reflects the place of service for each individual session (e.g., 11 is the code for "office" and is commonly used for general outpatient settings).
- 24D: **Procedures, services & supplies:** Provide the MNT CPT®, MNT G Codes or other codes. ([CPT and G codes for RDNs](#)) Modifiers may be required in some instances to provide additional information about a service and may impact the value of a CPT® code. (Telehealth is an example where payers may request use of a modifier.) Follow billing guidelines from each payer.
- 24E: **Diagnosis Pointer:** Indicate which diagnosis(es) from field 21 are addressed for each date of service.

- 24F: **Charges:** Provide the total charges for the visit, not the unit charge. The amount of the charge should be your usual and customary rate.
- 24G: **Days or units:** Include number of units for time-based CPT® and G codes. Refer to the [8-minute rule](#) for more information.
- 24J: **Rendering provider ID#:** Include the NPI of the RDN who provided the service.
- 25: **Federal Tax ID number:** Indicate Employer Identification Number (EIN) of the RDN (or of the organization), or social security number in absence of an EIN.
- 26: **Patient account number:** List only if specified by a payer (e.g., Medical Record Number).
- 27: **Accept assignment:** If credentialed with Medicare or any other payers, select “yes” to accept assignment. If you are out-of-network, contact the payer to understand the payer’s maximum allowable amount of payment for the CPT® codes, and the maximum amount that can be collected from the member when the service is provided by an out-of-network provider. If you accept assignment you cannot bill a patient beyond his/her/their financial responsibility (co-payment or share of cost). If you do not accept assignment, the payment may go to the patient in some situations.
- 28: **Total charge:** The total amount for all visits (Column F)
- 31: **Signature:** A signature is an attestation that the information provided is correct. An RDN signature is provided if the rendering provider is also the billing provider. In a practice setting, it would be the person submitting claims for the group practice (Field 33 billing provider).