

Reimbursement Policy

Claims Submission — Required Information for Professional Providers

Policy Number: **G-06029**

Policy Section: **Administration**

Last Approval Date: **5/6/2025**

Effective Date: **5/6/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://anthembluecross.com/ny/provider>.

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit nystateofhealth.ny.gov or call 855-355-5777.

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- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The health plan requires professional providers of healthcare services to submit an original CMS-1500 Health Insurance Claim Form, or its electronic equivalent, for payment of healthcare services, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Providers must submit a properly completed CMS-1500, or its electronic equivalent, for services performed or items/devices provided. If the required information is not submitted, we will deny payment without being liable for interest or penalties. The CMS-1500 claim form, or its electronic equivalent, must include the following information, if applicable:

- Patient information (name, address including zip code, date of birth, gender, relationship to insured, and medical condition as related to employment or an accident)
- Insured's information (member ID number, name, address including zip code, policy, group or FECA number, name of insurance plan or program, and name of other health benefit plan)
- Coordination of Benefits/other insured's information (name, policy or group number, and name of insurance plan or program)
- Name of referring physician or source
- Indication of outside laboratory
- ICD-10 diagnosis code(s)
- Clinical Laboratory Improvement Act certification number
- Date(s) of service(s) rendered
- Place of service
- Procedures, services, or supplies (description of services rendered using CPT-4 codes/HCPSC codes and appropriate modifiers)
- Charge(s) for service(s) rendered
- Day(s) or unit(s) related to service(s) rendered
- Total charges and amount paid by patient
- Federal Tax Identification Number

- Name and address of facility where services were rendered and the National Provider Identifier (NPI) of the service facility
- NPI:
 - Individual servicing provider's NPI must be reported as the rendering provider
 - When billing is from a group, the group's NPI must be reported as the billing provider
- NPI and other non-NPI identifier of the referring, ordering, or supervising provider
- Billing provider information (name, address including zip code, telephone number)
- Indication of signature on file – a handwritten or computer-generated signature for the provider of service or his/her representative – and date the form was signed
- National Drug Code(s) (NDC) to include the NDC number, unit price, quantity, and composite measure per drug

The health plan cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return.

The health plan prefers the submission of claims electronically through the Electronic Data Interchange (EDI) but will accept paper claims. A paper claim must be submitted on an original claim form with *drop-out red ink*, computer-printed or typed, in a large, dark font in order to be read by Optical Character Reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.

Providers should refer to their provider manuals and state-specific guidelines for details on claims submission requirements.

Related Coding

Standard correct coding applies.

Policy History

- **05/06/2025** - Review approved: no changes
- **06/09/2023** - Review approved and effective: added statement referencing provider manuals and state specific guidelines; added electronic equivalent
- **04/12/2021** - Review approved: minor language updates
- **04/30/2019** - Review approved: policy language updated
- **07/19/2017** - Review approved: policy language updated
- **07/13/2015** - Review approved: policy language updated; related policies updated
- **07/15/2013** - Review approved: policy template updated; policy language updated
- **11/05/2012** - Review approved: policy template updated; policy language updated

- **10/10/2011** - Review approved: policy template updated; policy language updated
- **08/10/2009** - Review approved: policy language updated
- **06/16/2006** - Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

- Claims Requiring Additional Documentation
- Claims Submission – Required Information for Facilities
- Corrected Claims
- Modifier Usage
- Unlisted or Miscellaneous Codes