How to Complete the CMS-1500 (For Patients)

The provider information and diagnosis and procedural codes have already been populated by our automated system based on the input of your lactation consultant. **The rest of the form must be completed by you** before submitting to your insurance company. This guide will help you complete the form accurately to ensure the highest rate of success.

Here are some tips to help you before you begin:

- Obtain the fax number or mailing address your submission needs to be sent to. This information may be dependent on your unique policy, so speaking with a representative from your insurance company might be preferential over simply researching on the Internet.
- Have your insurance card ready.
- Make sure that you are either a) the patient or b) authorized to sign on the patient's behalf. The form will need to be signed before it is submitted.
- Use a blue- or black-ink pen.
- Use only capital letters.
- Do not include any punctuation or stray marks.

Box 1 and 1a

Choose the health plan option that matches your policy. Most health plans are "Group Health Plans," but make sure you check the appropriate box based on the information that appears on your health insurance documents. Then, write your member ID number in box 1a.

Box 2

Write the name of the patient in the format [LAST NAME FIRST NAME MIDDLE INITIAL]. Depending on your insurance company's preferences, either the baby or the mother will be considered the patient during a lactation consultation. If you're not sure how to proceed, you should call your insurance company to find out the best way to fill out Box 2. Our diagnosis pointers are always referenced by the main diagnosis of the mother as per current standard guidelines. If this presents a problem, we would be happy to assist you by providing an amended form. Please contact us at 301-801-9070 or billing@metropolitanbreastfeeding.com

Box 3

Write the patient's date of birth in the format [MM DD YY], and also the patient's sex.

Box 4

The name that appears on the insurance card (or, the policy holder) should appear in this box in the format [LAST NAME FIRST NAME MIDDLE INITIAL].

Box 6

Check the box that most appropriately describes the relationship between the patient and the insured. Is the patient covered by insurance as self, spouse, child, other?

Box 7

Write the address and telephone number of the policy holder in this box. Even if the policy holder resides at the patient's address, this box still must be completed.

Box 9

If you are using supplemental insurance, you should check "Yes," then fill out the appropriate information in Box 9 and 9a-9d for your additional health insurance plan.

- Box 9: Write secondary insurance holder's name (Last, First)
- Box 9a: Write the secondary insurance plan's group number (should be located on insurance card under "GRP")
- Box 9d: Write secondary insurance plan's name (eg, CareFirst Federal Employee Program)

If you only have one health insurance plan, check "No," leave these boxes blank, and move on to Box 12.

Box 11 and 11a-11d

The information in this box pertains to the policy holder. In box 11, write the group number (found on your insurance card). In box 11a, write the policy holder's date of birth in the format [MM DD YY], and also the policy holder's gender. Leave box 11b blank. In box 11c, write the name of your insurance program and the name of your insurance company. If you are not sure what your insurance program is, this information should be found on your insurance card. If you still cannot locate the type of insurance program you have, writing only the name of your insurance company will suffice. Finally, in box 11d, you should check which box applies to you.

If you have any further questions about the completion of your portion of the CMS-1500, please contact Emily at: billing@metropolitanbreastfeeding.com 301-801-9070