

**Subpart C—Claims for Payment****§ 424.30 Scope.**

This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by an MA organization, or through cost settlement with either a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP), or as part of a demonstration. Therefore, claims must be filed by hospitals seeking IME payment under § 412.105(g) of this chapter, and/or direct GME payment under § 413.76(c) of this chapter, and/or nursing or allied health education payment under § 413.87 of this chapter associated with inpatient services furnished on a prepaid capitation basis by an MA organization. Hospitals that must report patient data for purposes of the DSH payment adjustment under § 412.106 of this chapter for inpatient services furnished on a prepaid capitation basis by an MA organization, or through cost settlement with an HMO/CMP, or as part of a demonstration, are required to file claims by submitting no pay bills for such inpatients. Special procedures for claiming payment after the beneficiary has died and for certain bills paid by organizations are set forth in subpart E of this part.

[77 FR 53682, Aug. 31, 2012]

**§ 424.32 Basic requirements for all claims.**

(a) A claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions.

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD-9-CM.

(3) A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with § 424.36).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.

(b) The prescribed forms for claims are the following:

CMS-1450—Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

CMS-1490S—Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

CMS-1500—Health Insurance Claim Form. (For use by physicians and other suppliers to request payment for medical services.)

CMS-1660—Request for Information-Medicare Payment for Services to a Patient now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

(c) *Where claims forms are available.* Excluding forms CMS-1450 and CMS-1500, all claims forms prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, or organizations. The CMS-1450 and CMS-1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from CMS or any Social Security branch or district office, or from Medicare intermediaries or carriers. The CMS-1490S is also available at local Social Security Offices.

(d) *Submission of electronic claims—(1) Definitions.* For purposes of this paragraph, the following terms have the following meanings:

(i) *Claim* means a transaction defined at 45 CFR 162.1101(a).

(ii) *Electronic claim* means a claim that is submitted via electronic media. A claim submitted via direct data entry is considered to be an electronic claim.

(iii) *Direct data entry* is defined at 45 CFR 162.103.

(iv) *Electronic media* is defined at 45 CFR 160.103.

(v) *Initial Medicare claim* means a claim submitted to Medicare for payment under Part A or Part B of the Medicare Program under title XVIII of the Act for initial processing, including claims sent to Medicare for the first time for secondary payment purposes.