

Special Instructions for Submitting Claims on the CMS-1500 for Members with Commercial Insurance

Providers submitting paper claims must refer to the [MassHealth Billing Guide for the CMS-1500](#).

Important: The table below lists specific fields on the CMS-1500 that must be completed for all MassHealth claims where the member has **commercial insurance** in addition to MassHealth. In addition to completing all applicable fields, all claims for members with other insurance must be submitted with the appropriate explanation of benefits (EOB) or other necessary TPL documentation. Providers must ensure that the appropriate carrier code is clearly written on each EOB.

Scenario: MassHealth member, Rhonda Rocket, sees her provider for medical services. Rhonda also has insurance coverage through both Blue Cross/Blue Shield (BC/BS) and ABC Corp. The total charge for her claim is \$100.00. A combined total of \$25.00 has been paid by other insurance carriers (BC/BS and ABC Corp.).

| Field # | Field Name | TPL Required Information | Example |
|---------|---------------------------------------|---|---|
| 1 | Unnamed | Check box marked "Medicaid." | Medicaid |
| 1a | Insured's ID Number | 12-digit MassHealth member ID | 111122223333 |
| 4 | Insured's name | If the member has other insurance, and if the subscriber's name is different from that in Field 2, enter the subscriber's name. | Last, First, Middle Initial |
| 6 | Patient Relationship to Insured | Relationship of the patient to the insured | X <input type="checkbox"/> Self |
| 11 | Insured's Policy Group or FECA Number | Enter the policy or group number of the first commercial insurance resource as it appears on the member's insurance card. | For BC/BS, use MM54321 |
| 11a | Insured's Date of Birth, Sex | Date of birth of the primary commercial insurance subscriber | 01/01/1940 X <input type="checkbox"/> F |
| 11c | Insurance Plan or Program Name | Enter the seven-digit MassHealth TPL carrier code for the | BC/BS carrier code 002700 (primary insurance carrier) |

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|---------|--|--|--|
| | | commercial insurance. | |
| 11d | Is There Another Health Benefit Plan? | Check box indicating whether the patient has insurance in addition to MassHealth and the commercial insurance identified in Fields 11-11c. If this box is checked "yes," complete Fields 9 and 9a-9d with information applicable to the other commercial health plan. | X <input checked="" type="checkbox"/> Yes |
| 9 | Other Insured's Name | If 11d is checked "yes," enter the name of the subscriber, if different from that in Field 2. | Last, First, Middle Initial |
| 9a | Other Insured's Policy or Group Number | If 11d is checked "yes," enter the group or policy number for the commercial insurance plan. | For ABC Corp., use 987654321A |
| 9b | Other Insured's Date of Birth, Sex | If 11d is checked "yes," enter the date of birth and gender of the policyholder noted in Field 9. | 01/01/1940 X <input checked="" type="checkbox"/> F |
| 9d | Insurance Plan Name or Program Name | If 11d is checked "yes," enter the seven-digit MassHealth TPL carrier code. | ABC Corp. carrier code 9991001 (Other insurance carrier) |
| 27 | Accept Assignment? Yes or No | For Other Insurance Non-Crossover Claims: Leave this field | [Blank] |

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|------------|----------------|---|--|
| | | blank. | |
| 29 | Amount Paid | Enter the total amount paid by all insurers other than MassHealth. | \$25.00 |
| Attachment | TPL Attachment | In addition to completing all applicable fields, all claims for members with other insurance must be submitted with the appropriate explanation of benefits (EOB) or other necessary TPL documentation. Providers must ensure that the appropriate carrier code is clearly written on each EOB. | EOB 1 – BC/BS carrier code 0027000 EOB 2 – ABC Corp. carrier code 9991001 |