

CMS 1500 Instructions

The following sections must be completed correctly or the bill will be returned and payment may be delayed or rejected.

1A* & 23*	CalVCP Application Number/Insured's ID Number
2	Claimant's Name
3	Claimant's Date of Birth
5	Claimant's address/Phone number
11	Insurance Policy information
11A	Insured's Date of Birth
11B	Employer's Name or School Name
11C	Insurance Plan name or Program Name
11D	Additional Health Plans
17	Treating Mental Health Provider and Licensure
19	Supervisory Mental Health Provider Licensure; if applicable
21 & 24E	Diagnosis Codes from current Diagnostic Statistical Manual
24A	Dates of services (Please list a minimum of 4 service dates per CMS 1500)
24B	Identify place of treatment – Office (O) or Home (H)
24D	Procedure Codes – see common CPT Codes on VCGCB.ca.gov
24E	Diagnosis Codes from current Diagnostic Statistical Manual
24F	Charges – Your normal rate for the service provided
24G	Units (please use hourly increments) for ½ hours please use .5 and 1 for 60 minutes (see Chart on website)
24J	Intern's Registration Number; if applicable
25	Tax Id/SSN/FEIN Number of payee as registered with IRS
28	Total Charges/Billed Amount
29	Amount paid by claimant, or another reimbursement source
30	Balance due
31	Provider/Treating/Supervising Therapist's Name, License Number, Signature/Signature stamp and date
32	Name & address where services rendered if different than box 33
33	Provider/Payee's name as registered with IRS, address & phone number