CMS-1500 Paper Claim Checklist

Use this before printing or mailing a professional paper claim.

Patient & coverage

■	Patient name/ID matches payer eligibility record
■	Insured/subscriber relationship is correct
■	Other coverage information is present when applicable
■	Accident/employment indicators are consistent with the claim

Provider & identifiers

■	Billing provider identity/NPI matches enrollment
■	Rendering provider NPI is on the correct service line when required
■	Service facility information is complete when required
■	Federal tax ID is the correct EIN/SSN for the billing entity

Clinical & service lines

■	Diagnosis codes are complete and current for the claim
■	Every service line has the correct procedure/modifier
■	Diagnosis pointers connect each service line to the right diagnosis
■	Dates, POS, units and charges match source documentation
■	Prior authorization/reference number is included when required

Totals & routing

■	Line charges reconcile to total charge
■	Amount paid and assignment indicators are correct if used
■	Correct payer address/routing destination is used
■	Corrected/replacement claim information is supplied when applicable

Paper printing

■	Use an acceptable OCR-red CMS-1500 form for paper submission
■	Verify scale is 100% / no “fit to page” distortion
■	Run printer-alignment test before batch printing
■	Check that no text touches boxes, lines, barcodes or optical marks
■	Keep a copy of the submitted claim and mailing/transmission record

Not an eligibility or coding determination. This checklist catches common completeness/routing issues. Payer edits, code-set requirements and medical-necessity rules still apply.

Official references: CMS / NUCC: cms.gov/medicare/billing/electronicbillingeditrans/1500 · nucc.org