

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

Revised 2011.12.14

DISCLAIMER: This document is intended to be a helpful guide, but users should not rely on any part of it as a definitive statement about claims submission. The Ohio Department of Job and Family Services has taken great care to ensure that the information in this document is accurate, but there may be inadvertent errors of typography or fact, and the content may have been superseded. Therefore, no warranty, either express or implied, is made for its usability with a particular claim.

Field 1 [Type of Insurance]

Check 'Medicaid'.

Field 1a Insured's ID. Number

Enter the 12-digit Billing Number from the individual's medical card. Do not use any other number.

Field 2 Patient's Name

Enter the individual's last name, first name, and middle initial, if any, as shown on the medical card.

Field 3 Patient's Birth Date and Sex

Leave this field blank.

Field 4 Insured's Name

Leave this field blank. The Medicaid-eligible individual is the insured person.

Field 5 Patient's Address

Leave this field blank unless the claim is for an abortion service.

Field 6 Patient Relationship to Insured

Leave this field blank. The Medicaid-eligible individual is the insured person.

Field 7 Insured's Address

Leave this field blank.

Field 8 Patient Status

Leave this field blank.

Field 9 Other Insured's Name

Leave this field blank. If the individual has health insurance coverage other than Medicaid, STOP. Claims for which there is a payer other than Medicaid (such as Medicare, a third-party commercial payer, or another non-commercial payer) will not be accepted on paper. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Field 9a Other Insured's Policy or Group Number

Leave this field blank. See Field 9.

Field 9b Other Insured's Date of Birth and Sex

Leave this field blank. See Field 9.

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

Field 9c Employer's Name or School Name

Leave this field blank. See Field 9.

Field 9d Insurance Plan or Program Name

Leave this field blank. See Field 9.

Field 10a-c Is Patient's Condition Related to:

Check 'YES' or 'NO' to indicate whether one or more of the services described in Field 24 is related to employment, an auto accident, or another accident.

Transportation Provider: Leave this field blank.

Field 10d Reserved for Local Use

Leave this field blank. If the individual has health insurance coverage other than Medicaid, STOP. Claims for which there is a payer other than Medicaid (such as Medicare, a third-party commercial payer, or another non-commercial payer) will not be accepted on paper. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Field 11 Insured's Policy Group or FECA Number

Leave this field blank. The individual's 12-digit Billing Number is reported only in Field 1a.

Field 11a Other Insured's Date of Birth and Sex

Leave this field blank.

Field 11b Employer's Name or School Name

Leave this field blank.

Field 11c Insurance Plan or Program Name

Leave this field blank.

Field 11d Is There Another Health Benefit Plan?

If the individual has health insurance coverage other than Medicaid, STOP. Claims for which there is a payer other than Medicaid (such as Medicare, a third-party commercial payer, or another non-commercial payer) will not be accepted on paper. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Field 12 Patient's or Authorized Person's Signature

Leave this field blank.

Field 13 Insured's or Authorized Person's Signature

Leave this field blank.

Field 14 Date of Current Illness or Injury or Pregnancy:

Complete this field only on claims involving pregnancy. Enter the date of the last menstrual period in eight-digit format (MMDDCCYY), without spaces or separating characters such as hyphens or slashes.

Field 15 If Patient Has Had Same or Similar Illness, Give First Date

Leave this field blank.

Field 16 Dates Patient Unable to Work in Current Occupation

Leave this field blank.

Field 17 Name of Referring Provider or Other Source

If the individual was referred to you, enter the referring practitioner's name, and complete Field 17b.

Completion of this field is required on DME claims when the billing provider is a DME provider, a hospital, or a pharmacy.

Transportation Provider: An authorized practitioner must certify the necessity of all non-emergency transports. Enter the name of the certifying practitioner.

Field 17a [Medicaid Legacy Number of Referring Provider]

Leave this field blank. A referral can be made only by a provider with an NPI.

Field 17b NPI [of Referring Provider]

Enter the NPI of the referring provider named in Field 17.

FQHC and RHC: Leave this field blank. If the claim involves a Medicaid Managed Care Plan (MCP) supplemental (wraparound) payment, STOP.

Wraparound claims will not be accepted on paper. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Transportation Provider: An authorized practitioner must certify the necessity of non-emergency transports. Enter the NPI of the certifying practitioner.

Field 18 Hospitalization Dates Related to Current Services

Leave this field blank unless the claim involves home health services or private duty nursing.

Home Health Services Provider and Private Duty Nursing Provider: On a claim for services provided after a hospital stay, enter the date of discharge, in eight-digit format (MMDDCCYY), as the 'To' date. The date of discharge cannot be later than the date of service reported in Field 24A, but it can be up to 60 days earlier.

Field 19 Reserved for Local Use

Leave this field blank unless an exclusion from co-payment applies.

This field (also known as Remarks) is to be used to report clarifying information. Whenever a provider is instructed to enter information in "the remarks space on the invoice", the information should be entered in this field.

If a service is subject to a Medicaid co-payment (as described in rule 5101:3-1-09 of the Ohio Administrative Code) but an exclusion from co-payment applies (also as described in that rule), then no co-payment should be charged or collected.

The exclusion must be noted in this field on the claim form with the appropriate ten-character exclusion code:

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

Exclusion	Exclusion Code
The patient is pregnant, or the pregnancy ended within the past 60 to 90 days.	COPAY PREG
The patient is receiving hospice services.	COPAY HSPC
The patient received emergency services that are subject to a co-payment.	COPAY EMER

Note: There is a single space after the qualifier ‘COPAY’. This space must be entered to ensure correct adjudication of the claim.

Co-payment exclusion codes must always be reported first, before any other remarks, to ensure proper adjudication of the claim.

It is not necessary to indicate exclusions for individuals who are under the age of 21, who are receiving family planning services, or who are institutionalized (i.e., reside in a nursing facility or ICF). Such exclusions will be automatically detected by the adjudication system, and no co-payment will be assessed on services rendered to these individuals.

Field 20 Outside Lab and \$ Charges

Leave this field blank.

Field 21 Diagnosis or Nature of Illness or Injury

On most claims, a diagnosis code must be reported in this field. Enter all ICD-9 diagnosis codes in decreasing order of significance, up to a maximum of four, that apply for the services reported in Field 24.

Home Health Services Provider, Private Duty Nursing Provider, and ODJFS-Administered Waiver Provider: A diagnosis code is optional on claims with any of the following procedure codes: G0151, G0152, G0153, G0154, G0156, H0045, S0215, S5101, S5102, S5125, S5160, S5161, S5165, S5170, T1000, T1002, T1003, T1019, T2029.

Independent Laboratory, Independent Diagnostic Testing Facility (IDTF), and Portable X-Ray Supplier: A diagnosis code is optional.

Transportation Provider: For ground or air ambulance service, a diagnosis code is optional. For wheelchair van service, do not specify a diagnosis.

Field 22 Medicaid Resubmission Number and Original Reference Number

When resubmitting a denied claim, include under ‘Original Ref. No.’ the 13-digit MITS Internal Control Number (ICN) or the 17-digit MMIS Transaction Control Number (TCN) from the previous claim, whichever is applicable, in order to document timely filing. If additional space is needed, use Field 19.

Field 23 Prior Authorization Number

Complete this field only if prior authorization (PA) is required for the services reported on the claim. Use the PA number assigned by the Ohio Department of Job and Family Services (ODJFS) that is shown on the Prior Authorization notification. PA numbers generated by MITS have ten digits; MMIS-generated PA numbers have six digits.

Refer to the appropriate Medicaid program rules to determine which services require prior authorization.

ODJFS-Administered Waiver Provider: Complete this field on claims for supplemental adaptive assistive device services (T2029) or home modification services (S5165).

Private Duty Nursing Provider: For line items consisting of the procedure code/modifier combinations T1000U5 or T1000U6, prior authorization is required for dates of service 10/01/2006 or after, unless the individual is enrolled on an ODJFS-administered waiver.

Transportation Provider: Some transportation services require manual review. If such a service is approved, a PA number will be issued.

Field 24A Date(s) of Service

Enter the date of service, in eight-digit format (MMDDCCYY), as the 'From' date. Failure to enter a 'From' date will cause denial of the line item. Do not enter a 'To' date. A separate line is required for each date of service.

Note: All claims must be submitted to Medicaid within 365 days after the date of service (Ohio Administrative Code rule 5101:3-1-19).

Home Health Services Provider, Private Duty Nursing Provider, and ODJFS-Administered Waiver Provider: Each line represents a single visit. Multiple visits for the provision of the same service must be reported on separate lines but on the same claim. Two visits for the provision of the same service or services with the same scope must be separated by at least two hours, unless one of the exceptions for private duty nursing listed in rule 5101:3-12-02 or 5101:3-12-04 of the Administrative Code applies. Note: For a visit beginning in the late evening and continuing after midnight, the date of service is the date on which the visit began.

Hospice Provider: If the claim involves hospice room and board (T2046) for a resident of a long-term care facility (LTCF) and some days are covered by patient liability, STOP. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Field 24B Place of Service

A place of service must be reported on all claims except claims submitted by independent laboratories, portable X-ray suppliers, transportation providers, and independent diagnostic testing facilities (IDTFs).

Enter the appropriate place of service from the list below:

- 01 Pharmacy
- 03 School

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

- 04** Homeless Shelter
- 05** Indian Health Service Free-standing Facility
- 06** Indian Health Service Provider-based Facility
- 07** Tribal 638 Free-standing Facility
- 08** Tribal 638 Provider-based Facility
- 09** Prison/Correctional Facility
- 11** Office
- 12** Home
- 13** Assisted Living Facility
- 14** Group Home
- 15** Mobile Unit
- 16** Temporary Lodging
- 17** Walk-in Retail Health Clinic
- 20** Urgent Care Facility
- 21** Inpatient Hospital
- 22** Outpatient Hospital
- 23** Emergency Room – Hospital
- 24** Ambulatory Surgery Center
- 25** Birthing Center
- 26** Military Treatment Facility
- 31** Skilled Nursing Facility
- 32** Nursing Facility
- 33** Custodial Care Facility
- 34** Hospice (Facility)
- 41** Ambulance, Ground
- 42** Ambulance, Air or Water
- 49** Independent Clinic
- 50** Federally Qualified Health Center
- 51** Inpatient Psychiatric Facility
- 52** Psychiatric Facility – Partial Hospitalization
- 53** Community Mental Health Center
- 54** Intermediate Care Facility (for persons with mental retardation)
- 55** Residential Substance Abuse Treatment Facility
- 56** Psychiatric Residential Treatment Center
- 57** Non-residential Substance Abuse Treatment Facility
- 60** Mass Immunization Center
- 61** Comprehensive Inpatient Rehabilitation Facility
- 62** Comprehensive Outpatient Rehabilitation Facility
- 65** End-Stage Renal Disease Treatment Facility
- 71** State or Local Public Health Clinic
- 72** Rural Health Clinic
- 73** Clinic, Not Otherwise Specified
- 81** Independent Laboratory
- 99** Other Place of Service

Home Health Services Provider (Medicare Certified Home Health Agency):

For services rendered in the home, enter 12. For services rendered in a licensed child day-care center or in a setting where a child receives early intervention services (EI) as indicated in the individualized family service plan (IFSP), enter 99.

Hospice Provider: For room and board claims (T2046), the appropriate place-of-service codes are 31, 32, and 54. For respite (T2044) and general inpatient care (T2045), the appropriate place-of-service codes are 21, 31, 32, and 34.

ODJFS-Administered Waiver Provider: For services rendered in the home, enter 12. For out-of-home respite, enter 31, 32, 33, or 54, as appropriate. For other services rendered outside the home, enter 99.

Private Duty Nursing Provider: For services rendered in the home (the usual place of service), enter 12. For services rendered outside the home, enter 99.

Field 24C **EMG [i.e., Emergency]**

Leave this field blank.

Field 24D **Procedures, Services, or Supplies**

CPT/HCPCS

Enter the five-character CPT (HCPCS level I) or HCPCS level II procedure code that corresponds to the service rendered.

If the claim involves a National Drug Code (NDC), STOP. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

FQHC, OHF, and RHC: Enter encounter code T1015, along with the appropriate modifier. On subsequent lines, enter the procedure codes that correspond to the services rendered during that encounter. Procedure codes must immediately follow the encounter code with which they are associated.

Modifiers

Some procedure codes allow or require at least one two-character modifier. Up to four modifiers may be entered per line.

FQHC:

For a medical encounter, enter modifier U1.

For a dental encounter, enter modifier U2.

For a mental health services encounter, enter modifier U3.

For a physical therapy encounter, enter modifier U4.

For a speech therapy encounter, enter modifier U5.

For a podiatry encounter, enter modifier U6.

For a vision services encounter, enter modifier U7.

For a chiropractic encounter, enter modifier U8.

For a transportation encounter, enter modifier U9.

RHC:

For a medical encounter, enter modifier U1.

OHF:

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

- For a medical encounter, enter modifier U1.
- For a dental encounter, enter modifier U2.
- For a mental health services encounter, enter modifier U3.
- For a physical therapy encounter, enter modifier U4.
- For a speech therapy encounter, enter modifier U5.
- For a vision services encounter, enter modifier U7.
- For a transportation encounter, enter modifier U9.
- For a laboratory services encounter, enter modifier UA.
- For an X-ray services encounter, enter modifier UB.

Home Health Services Provider, Private Duty Nursing Provider, and

ODJFS-Administered Waiver Provider: An individual (child) receiving home health nursing (procedure code G0154) with increased hours of service (modifier U5) has a second nursing visit on a particular day (modifier U2) to get home infusion (modifier U1) in a group setting (modifier HQ). The line item for the visit would be entered on the claim thus: G0154 U5 U2 U1 HQ. Modifiers can be entered in any order.

Note: The group setting modifier HQ reduces reimbursement to 75% of the Medicaid maximum amount. HQ must be used even if only a portion of the visit took place in a group setting. Modifiers U2 and U3 (indicating multiple visits) are used with a single procedure code (e.g., G0154, G0154 U2, G0154 U3).

Transportation Provider: Modifiers can be grouped into three types: (1) point-of-transport, (2) payment adjustment, and (3) information. Each modifier consists of a pair of characters. In most cases, at least one point-of-transport modifier is required. As many as four modifiers may be used with a single procedure code.

Example: Two individuals requiring wheelchair van service are transported instead in an ambulance vehicle from their residence to a practitioner's office. On arrival, they find that the practitioner has been called away suddenly and has had to cancel their appointments. The procedure code and modifiers for the second passenger of this transport would be entered on the claim thus: A0428 U3 RP U1 U6. (The two-character modifiers may be entered in any order.)

Note: If the origin of a trip is a school or workplace, use the modifier U4 and do not specify the destination. If the destination of a trip is a school or workplace, use the modifier U7 and do not specify the origin.

“U-modifiers” for transportation claims:

- U1 – Second passenger
- U2 – Additional passenger beyond the second
- U3 – Ambulance used in lieu of a wheelchair van (only with A0428 and A0425)
- U4 – School or workplace (origin point)
- U5 – Origin/destination point not otherwise specified
- U6 – Service unavailable on arrival at destination
- U7 – School or workplace (destination point)

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

Field 24E Diagnosis Pointer

If at least one diagnosis code appears in Field 21, indicate the diagnosis (1, 2, 3, or 4) with which the line item is associated.

Field 24F \$ Charges

Enter your usual and customary fee for the service listed on this line.

FQHC, OHF, and RHC: Do not enter charges for line items listed subsequent to an encounter code.

Field 24G Days or Units

Enter the number of units of service provided. Only whole numbers may be reported. The following services may be reported in multiple units on one line: allergy tests, add-on codes specified in Appendix D of *Current Procedural Terminology*, time-based codes, medical supplier services, HCPCS codes in the J or Q series for injectables, certain diagnostic and therapeutic services, and certain surgical procedures.

Anesthesia Provider: Enter the number of actual anesthesia minutes.

FQHC, OHF, and RHC: Leave this field blank unless the service is anesthesia. For anesthesia, enter the number of minutes. Note: An OHF must report a laboratory or radiology service as an encounter without specifying units of service.

Home Health Services Provider, Private Duty Nursing Provider, and ODJFS-Administered Waiver Provider: Enter the appropriate number of units for the service/visit (1 unit = 15 minutes). Each visit is reimbursed at a base rate for the first hour plus a per-unit rate for each additional unit of service.

Hospice Provider: For procedure codes T2042, T2044, T2045, and T2046, enter '1'. For procedure code T2043, enter the number of units (1 unit = 1 hour).

Transportation Provider: For mileage procedure codes, enter the total number of loaded miles claimed. For all other procedure codes, enter '1'.

Field 24H EPSDT/Family Planning

Lower, Unshaded Area

Enter 'E' if the service was related to Healthchek (EPSDT).

Enter 'F' if the service was related to family planning.

Enter 'B' if the service was related to both Healthchek (EPSDT) and family planning.

Otherwise, leave this field blank.

Upper, Shaded Area

If either 'E' or 'B' is entered in the lower, unshaded area, then add an explanatory two-character indicator:

Enter 'NU' if no Healthchek (EPSDT) referral was given. The combination 'E / NU', for example, may denote that a Healthchek exam was given and no further treatment was necessary.

Enter 'AV' if a referral was offered but the individual refused it.

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

Enter ‘ST’ if the screening provider has scheduled the individual for another appointment, or has referred the individual to another provider, for diagnostic or corrective treatment of at least one health problem identified during a Healthchek (EPSDT) screening. Do not use this indicator for dental treatment referrals.

Enter ‘S2’ if the individual is currently being diagnosed or treated for a health problem by the provider as a result of a Healthchek (EPSDT) referral.

Otherwise, leave this field blank.

Field 24I ID. Qualifier

In the shaded area above ‘NPI’, enter the two-character qualifier ‘1D’ (numeral one, letter D) ONLY IF you must enter a seven-digit Medicaid legacy provider number in the shaded area of Field 24J.

Field 24J Rendering Provider ID. Number

Do not submit claims to Ohio Medicaid with multiple rendering providers on a single claim form. Submit a unique claim for each rendering provider, even if the services were rendered by members of the same group practice (billing provider). If a single claim is submitted with more than one rendering provider, only the first NPI listed in Field 24J will be used.

Medical practitioners and other “typical” healthcare providers must enter the National Provider Identifier (NPI) of the rendering provider. Claims submitted by typical providers without an NPI will be denied.

“Atypical” providers that furnish only non-healthcare services are not required to obtain an NPI; they can continue to submit claims with only their seven-digit legacy Medicaid provider number. An atypical provider that has obtained an NPI, however, must enter it.

All claims submitted with the legacy generic “dummy” provider number 9111115 will be denied.

The rendering provider ID number (reported in Field 24J) and the billing provider ID number (reported in Field 33a or 33b) must be the same for the following providers:

Typical Providers

- Ambulance provider
- Ambulatory surgery center (ASC) rendering a facility service
- Clinic
- DME supplier
- Federally qualified health center (FQHC)
- Home health services provider
- Hospice provider rendering a hospice service represented by HCPCS procedure code T2042, T2043, T2044, T2045, or T2046
- Independent diagnostic testing facility (IDTF)
- Independent laboratory
- Individual practitioner
- Outpatient health facility (OHF)

ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (08/2005)

Portable X-ray supplier
Private duty nursing provider (individual nurse)
Rural health clinic (RHC)
Atypical Providers
Independent provider of waiver services
Wheelchair van provider

Field 25 Federal Tax ID. Number

Enter the provider's Employer Identification Number (EIN).

Field 26 Patient's Account No.

This optional field is for the provider's use in identifying an individual. Up to nine numbers or letters may be entered; no other characters are allowed. This number will appear on the remittance advice with the label 'Med. Rec.'

Field 27 Accept Assignment?

Leave this field blank. Providers must always accept assignment for Medicaid-eligible individuals.

Field 28 Total Charge

On the last page of the claim, enter the sum of all charges reported in Field 24F of all pages.

Field 29 Amount Paid

Leave this field blank. If the individual has health insurance coverage other than Medicaid, STOP. Claims for which there is a payer other than Medicaid (such as Medicare, a third-party commercial payer, or another non-commercial payer) will not be accepted on paper. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Hospice Provider: If the claim involves hospice room and board (T2046) for a resident of a long-term care facility (LTCF) and some days are covered by patient liability, STOP. Such claims must be submitted through the MITS Web Portal or by electronic data interchange (EDI) transaction.

Field 30 Balance Due

On the last page of the claim, enter the total charge reported in Field 28.

Field 31 Signature of Physician or Supplier Including Degrees or Credentials

Have an authorized representative of the provider sign and date the claim form here.

Field 32 Service Facility Location Information

Field 32a

Field 32b

Leave these fields blank.

Field 33 Billing Provider Information and Phone Number

Enter the name, mailing address, city, state, and ZIP Code that correspond to the identification number reported in Field 33a or 33b.

Note: Paragraph (F) of rule 5101:3-1-17.2 of the Ohio Administrative Code requires providers to inform ODJFS within thirty days of any change of address.

Field 33a [NPI of Billing Provider]

Medical practitioners and other “typical” healthcare providers must enter the National Provider Identifier (NPI) of the billing provider. Claims submitted by typical providers without an NPI will be denied.

“Atypical” providers that furnish only non-healthcare services are not required to obtain an NPI; they can continue to submit claims with only their seven-digit legacy Medicaid provider number. An atypical provider that has obtained an NPI, however, must enter it.

The rendering provider ID number (reported in Field 24J) and the billing provider ID number (reported in Field 33a) must be different for the following providers:

Typical Providers

- Ambulatory surgery center (ASC) rendering a professional service
- Hospice provider rendering a practitioner service
- Professional group practice

Field 33b [Medicaid Legacy Number of Billing Provider]

“Atypical” providers that furnish only non-healthcare services are not required to obtain an NPI; they can continue to submit claims with only their seven-digit legacy Medicaid provider number, which must be entered in this field. An atypical provider that has obtained an NPI, however, must enter it in Field 33a.

All claims submitted with the legacy generic “dummy” provider number 9111115 will be denied.

The rendering provider ID number (reported in Field 24J) and the billing provider ID number (reported in Field 33a or 33b) are the same for atypical providers.

MAIL THIS CLAIM TO:
Ohio Department of Job and Family Services
P.O. Box 7965
Akron, OH 44306

DO NOT FOLD THE CLAIM FORM.

TIPS FOR SUBMITTING PAPER CLAIMS

Keep the claim form clean, undamaged, and free from debris.

- Use an original, preprinted form. Photocopies and faxes are not acceptable. The CMS-1500 and UB-04 forms are printed with distinctive red "drop-out" ink.
- Be sure that the paper is thick enough (20- or 22-lb.) to keep any printing on the back from showing through and the form from jamming the scanner. But do not use card stock.
- Do not fold or crease the claim form. Mail it in an envelope that is at least 9" x 12".
- Do not mar the paper with correction fluid, staples, sticky notes, or food stains.

Complete the form with a view toward scanning.

- Use a computer printer or a typewriter. Do not fill in information by hand.
- Enter information only in applicable fields.
- CAPITALIZE ALL LETTERS.
- Do not add descriptions of procedure codes, modifiers, or diagnosis codes.
- Left-justify the entry in a field. Keep the entry within the field; make sure that no content touches or runs beyond the boundaries of the field.
- Do not add notations, circles, scribbles, overstrikes, or cross-outs. Do not apply correction fluid, labels, stickers, or rubber stamp impressions.
- Omit honorifics (Ms., Dr., etc.) from names.
- Omit punctuation marks, symbols, and special characters (e.g., hyphens, periods, parentheses, dollar signs, and ditto marks).
- Print or type with a standard font. Do not use italic, script, or artistic fonts.
 - Use black toner or ink (even on forms printed in red). Laser printers turn out pages with more consistent color density (darkness). If an inkjet printer or a typewriter is used, check the cartridge or ribbon frequently and change it as necessary.
 - Select a legible typeface. Some sources suggest that a sans serif font (such as Arial or Lucida Console) may produce better scanning results than a serif font (such as Times New Roman or Courier).*
 - Choose a standard size (from 10 to 12 points in height) or pitch (10 or 12 characters per inch in width). Do not use small or condensed fonts.
 - Make sure that the lines and curves of printed or typed characters are continuous and smooth, not broken up like stenciling or early dot-matrix printing.

Keep a few additional details in mind.

- A paper attachment should be no smaller than 8.5" x 11".
- Attachments must be received no later than 14 days after the claim has been submitted. An attachment must be either uploaded through the Web Portal or mailed with a cover page generated in the Web Portal.
- A claim form that cannot be processed will be returned with a letter indicating the reason for its return.

Remember, the form you submit will be read by a machine. If you can't read it, the machine probably can't either.

* Serifs are little flourishes at the ends of strokes that make up a letter. The letter **m** printed in Times New Roman has serifs; the letter **m** printed in Arial does not.