

**NJ FamilyCare**  
**Housing Supports**  
**January 13, 2026**

**Instructions for Completing the CMS-1500 Claim Form for the Housing Supports Program**

The Center of Medicaid and Medicare Services (CMS) [form 1500](#) must be used to bill for Housing Supports services. The form is typically used by health care professionals to submit claims for health care services. Please find below step-by-step instructions for how to complete this form if submitting a claim for Pre-tenancy and Tenancy Sustaining Services. Please note that all fields are required, unless noted as optional or if the user is instructed to leave the field blank. Providers may submit claims by paper, through EDI (Electronic Data Interchange), or via MCO portals. The guidance below should mirror all claims formats.

For complete guidance on how to fill out the CMS-1500, providers should refer to the National Uniform Claim Committee's reference instruction manual.

Disclaimer: The below directions are intended to provide directions on how to submit a payable claim. However, each individual claim may have nuances and policies may vary by MCO. Please reach out to your MCO with any questions.

<b>Field</b>	<b>Provider guidelines</b>
1: Type of insurance	Mark 'Medicaid' only.
1A: Insured's Medicaid ID	Enter the member's ID number as shown on the member's MCO ID card. Please note that Wellpoint may label Medicaid ID as "Subscriber #" on the member's ID card.  The ID should reflect the member's ID with the MCO, which might be different than their state-issued Medicaid ID.
2: Patient name	Enter the member's full last name, first name, and middle initial separated by commas (e.g., Doe, John, S).  Do not include periods, credentials (e.g., PhD, Dr), or nicknames.
3: Patient DOB, sex	Enter the member's 8-digit birth date (MM   DD   YY) and enter an 'X' in one box to indicate sex of the member.  Note: DOB is important to input accurately, as it may be used to identify the member in MCOs' data to ensure a match.

4: Insured's name	Enter the member's full last name, first name, and middle initial (This should be the same as field 2).
5: Patient address	<p>Enter the member's complete address; the first line is street address (incl. unit number, if applicable), the second line is city and state, and the third line should include a 5-digit zip code. Telephone may be left blank.</p> <p>Do not include punctuation in the address (e.g., Apt 107 instead of Apt. #107)</p> <p>If member does not have a stable address, may input the address listed for the member's Medicaid enrollment or shelter address.</p>
6: Patient relationship to insured	Mark 'X' in 'Self' only.
7: Insured's address	Leave blank
8: Reserved for NUCC use	Leave blank.
9: Other Insured's name	This field should be filled in only if marking 'X' for "Yes" in 11D (i.e., member has another insurance coverage). If so, must include name (full last name, first name, and middle initial) of other insurance holder.
9A: Other Insured's policy / group number	This field should be filled in only if marking 'X' for "Yes" in 11D (i.e., member has another insurance coverage). If so, must include policy or group number of other insurance.
9B: Reserved for NUCC use	Leave blank.
9C: Reserved for NUCC use	Leave blank.
9D: Insurance Plan Name or Program Name	This field should be filled in only if marking 'X' for "Yes" in 11D. If member has another insurance coverage to include, must enter name of other plan or program.

10A: Is patient's condition related to employment?	Check off Yes or No. Likely to mark no - only mark yes if the service is directly related to a work-place accident.
10B: Is patient's condition related to auto accident?	Check off Yes or No. Likely to mark no - only mark yes if the service is directly related to an auto accident
10C: Is patient's condition related to other accident?	Check off Yes or No. Likely to mark no - only mark yes if the service is related to an accident other than an auto accident
10D: Claim codes (designated by NUCC)	Leave blank.
11: Insured's policy group or FECA number	Leave blank.
11A: Insured's DOB, sex	Same as Box 3. Enter the member's 8-digit birth date (MM   DD   YY) and enter an 'X' in one box to indicate sex of the member.
11B: Insured's other claim ID (designated by NUCC)	Leave blank.
11C: Insured's insurance plan / program name	Input name of insurance associated with member's MCO, e.g.: - Aetna Better Health of NJ - Fidelis Care (for Medicaid/Core Caid); Wellcare for FIDE-SNP - Horizon NJ Health - UHC Community Plan of NJ or United HealthCare Community Plan or NJ FAMCAR or NJ DUALCM - Wellpoint NJ
11D: Insured - is there another health benefit plan	Check 'Yes' or 'No' to indicate if there is another health benefit plan for the member; if yes, must complete 9, 9A, 9D.

12: Patient or authorized person's signature	Leave blank.
13: Insured's or authorized person's signature	Enter 'Signature on File' ('SOF'). Provider should ensure that they have the signature of the member on file.
14: Date of current illness, injury, or pregnancy	Leave blank
15: Other date	Leave blank
16: Dates patient unable to work in current occupation	Leave blank
17: Name of referring provider or other source	Leave blank
17A: Referring provider - other ID	Leave blank
17B: Referring provider NPI	Leave blank
18: Hospitalization dates related to current services	Leave blank

<p>19: Additional claim information (designated by NUCC)</p>	<p>Leave blank</p>
<p>20: Outside lab information</p>	<p>Leave blank</p>
<p>21: Diagnosis or nature of illness or injury</p>	<p>Use this field to enter the diagnosis code associated with the claim. Some MCOs will deny a claim if the code listed on the authorization form does not match the code on the claim form. We recommend cross-checking codes between forms before submitting claims.</p> <p>In the "ICD Ind." field, enter 0 if you are entering an ICD-10 code. However, if using an ICD-9-CM code, use 9 as the indicator in the first field. Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field. Most likely to enter 0 since ICD-9 codes are legacy codes. Typically, ICD-10 codes are alphanumeric and are up to 7 characters, while ICD-9 codes are 3-5 characters in length and are typically numeric. If unsure if the code is ICD-10 or ICD-9, recommend checking through CMS website.</p> <p>Enter the applicable diagnosis codes starting in the field marked 'A'. You may enter up to 12 codes (one code for A-L). However, we expect that only one diagnosis code is necessary. The remaining lines (B-L) may be left blank, assuming no other additional diagnosis codes apply.</p> <p>See Housing Supports provider guidance for applicable situations and associated ICD-10 codes. Providers may interpret ICD-10 codes for this field as Z codes, which are a type of ICD 10 code used to define health related social needs. For example, the ICD-10 code for sheltered homelessness is Z59.01. Please note that MCOs may authorize services under the generic ICD-10 code (Z00.00). Again, best practice to cross-reference the code on the authorization form with the claim form.</p>

<p>22: Resubmission code</p>	<p>Enter the appropriate bill frequency code:  1: Initial submission  7: Replacement of prior claim  8: Void/cancel of prior claim</p> <p>Include the original reference number if associated with previously submitted claim. For example, if coding as #7, the provider should include the original claim number from the first claim submission under "original ref. no."</p>
<p>23: Prior authorization number</p>	<p>Include prior authorization number authorizing the service this claim is for; providers typically may find this number on their authorization approval letter and/or in the MCO's provider portal.</p> <p>Not all MCOs require this number on the claims form, but it is recommended to include as a best practice.</p>
<p>24A: Date(s) of service</p>	<p>Best practice is to input dates of the full 30-day billing period, associated with the relevant billing period under members' authorization. Use format MM   DD   YY.  For example:  - "From": 1st day of billing period (e.g., 01   01   26)  - "To": last day of billing period (e.g., 01   30   26)</p> <p>Note that providers may only be paid 1x per billing period and should submit 1 claim per 30-day billing period (i.e., do not submit a claim each time a touchpoint is made).</p> <p>If billing for multiple 30-day billing periods, list each 30-day billing period in separate lines.</p> <p>Note: some MCOs may accept date ranges less than but within the 30-day billing period.</p>

<p>24B: Place of service</p>	<p>Enter a valid place of service code (POS), as identified by CMS. Please reference CMS' <a href="#">list</a> of valid codes. Please enter the code that most closely captures where services were rendered throughout the month. If services were rendered in multiple locations, may also enter 99 (Other place of service). As a reminder, at least half of member touchpoints must be in person.</p> <p>We expect the following five codes to be the common POS codes for providers to enter, which all MCOs accept: 04 (Homeless shelter); 12 (Home); 16 (Temporary lodging); 27 (Outreach site/street); 99 (Other place of service).</p> <p>Some MCOs may deny a claim if the Place of Service code indicates a member is ineligible for services (e.g., 09 may indicate a member is in prison). Still recommend entering the code that accurately captures where services were rendered and, if denied, connecting with your MCO to understand reasons for denial.</p> <p>If unsure on location even after reviewing all valid CMS options, may enter POS 99.</p>
<p>24C: Emergency indicator</p>	<p>Leave blank</p>
<p>24D: Procedure code</p>	<p>Enter 'H0044' (Tenancy Services) and modifier (indicating Pre-tenancy Services vs. Tenancy Sustaining Services and Level of Need), as listed on the prior authorization.</p> <p>Modifiers for tenancy-related services include:  U1: Lower level of need for pre-tenancy services  U3: Higher level of need for pre-tenancy services  U4: Lower level of need for tenancy-sustaining services  U6: Higher level of need for tenancy-sustaining services</p> <p>As a reminder, if a member is authorized for a higher level of need but the provider is only able to deliver 2-3 touchpoints in a given billing cycle, the provider may bill for the lower level of need rate. If this scenario applies to you, enter the modifier associated with the lower level of need in this field. <b>The procedure code on the authorization form will not match your entry on this form as a result.</b> Recommend connecting with your MCO to ensure successful claims submission in this circumstance.</p>
<p>24E: Diagnosis pointer</p>	<p>Field 24E links the diagnosis code(s) in Field 21 to the specific service line being billed. If the diagnosis code in Field 21 is listed under "A", the provider should enter "A" in Field 24E. If the code is in Field B, enter "B"; if in Field C, enter "C"; and so forth. At least one diagnosis reference (A, B, C, or D – sometimes displayed as 1, 2, 3, 4 in online portals) must be included. Multiple letters can be entered if the service line relates to more than one diagnosis, but most likely only one entry is necessary.</p>

<p>24F: Charges</p>	<p>Provider should indicate charge equal to state-defined rate of procedure code. Note: MCOs may only pay up to the billed amount (the amount requested on the claim) if billed for a lower value than the state-defined rate.</p> <p>Do not include dollar sign or negative amounts; enter "00" in cents area if amount is a whole number.</p>
<p>24G: Days or units</p>	<p>Enter 1 (1 unit = one 30-day billing period), regardless of number of touchpoints made. Note: provider should only submit claim if minimum required touchpoints were made.</p> <p>If billing for multiple 30-day billing periods, list each 30-day billing period in separate lines, with 1 unit per 30-day billing unit.</p>
<p>24H: EPSDT family plan</p>	<p>Leave blank</p>
<p>24I: ID qualifier</p>	<p>If MCO is Aetna, Fidelis, UHC, or Horizon: Enter 'ZZ'. The 'ZZ' code indicates a rendering provider taxonomy qualifier.</p> <p>The ZZ code informs the MCO of the kind of information the provider is entering in follow-up fields. When entering ZZ, it signals that entries in related fields are provider taxonomy codes. Without the "ZZ," MCOs might assume the entry is related to a different category (e.g., state license numbers).</p> <p>If MCO is Wellpoint: Leave blank</p>
<p>24J: Rendering provider ID</p>	<p>If MCO is Aetna, Fidelis, UHC, or Horizon: In shaded area (top), include non-NPI ID number (i.e., taxonomy code associated with NPI). For Pre-tenancy or Tenancy Sustaining services, the taxonomy will be '251B00000X'.</p> <p>In non-shared area, include provider's Type II NPI (the NPI for which the provider is credentialled for). Note that all credentialled Housing Supports Tenancy Services providers must have Type II NPIs.</p> <p>If MCO is Wellpoint: Leave blank</p>
<p>25: Federal Tax ID Number (SSN / EIN)</p>	<p>Provider organization 9-digit tax ID number. Select 'X' for EIN.</p>
<p>26: Patient's account number</p>	<p>Enter a provider-designated unique member identifier. This field is helpful for provider organization's internal tracking.</p>

27: Accept assignment?	Select 'yes' to indicate that the provider agrees to accept assignment under the terms of the Medicaid program.; Only 1 box can be selected.
28: Total charge	Please total up all the charges listed on 24F.  Do not include dollar sign or negative amounts; enter "00" in cents area if amount is a whole number.
29: Amount paid (from other coverage)	Leave blank.
30: Reserved for NUCC use	Leave blank.
31: Physician signature and degrees / credentials	If MCO is Aetna, Fidelis, Horizon, or UHC, enter agency's name in this field and do not provide a signature. If MCO is Wellpoint, leave blank.
32: Service facility location information	Some MCOs require, others do not; recommend entering servicing facility address when different from the billing address that is entered in box 33. If the billing address is the same as the service location, box 32 can be left blank.
32A: Service facility location information - NPI #	Some MCOs require, others do not; recommend inputting the NPI number of the service facility location. Can be left blank if the billing facility is the same as the service facility.
32B: Service facility location information - other ID #	Some MCOs require, others do not; recommend entering the qualifier identifying the non-NPI number followed by the ID number (see instructions for 33B). Can be left blank if the billing facility is the same as the service facility.

<p>33: Billing provider - name, address, phone number</p>	<p>Enter the provider's complete address, including:  Top right corner: Phone number  1st line: Provider Name  2nd line: Street address (incl. unit number, if applicable)  3rd line: City state (2 digit code) and 5-digit zip code</p> <p>Do not include punctuation or commas in the address (e.g., Apt 107 instead of Apt. #107).</p> <p>Please use the same address used on the credentialing application.</p>
<p>33A: Billing provider info and phone number - NPI #</p>	<p>Include provider's Type II NPI (the NPI for which the provider is credentialed for). Note that all credentialed Housing Supports Tenancy Services providers must have Type II NPIs.</p>
<p>33B: Billing provider info and phone number - other ID #</p>	<p>Enter 'ZZ' and the non-NPI ID number (i.e., taxonomy code associated with NPI). For Pre-tenancy or Tenancy Sustaining services, this box will be 'ZZ251B00000X'</p> <p>The ZZ code informs the MCO of the kind of information the provider is entering. When entering ZZ, it signals that entries in related fields are provider taxonomy codes. Without the "ZZ," MCOs might assume the entry is related to a different category (e.g., state license numbers).</p>