

HCFA 1500 Box 32 - Setting the Service Location

Last modified on 03/19/2026 11:13 am EDT

If you are seeing patients outside of your normal office location, the service location address must be disclosed in box 32 of the HCFA 1500 form, along with the POS code that coordinates with the service location.

This article will explain how to update this information in your office settings, so the accurate service location, Place of Service (POS) code, and remit office information are all populated correctly.

- HCFA Box 24B - Blue - Place of Service (POS) code
- HCFA Box 32 - Black - Service Facility Location
- HCFA Box 33 - Green - Billing Provider Information

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE		ORIGINAL REF. NO.							
A. W56.01XA		B. W56.02XA		C.		D.		E.		23. PRIOR AUTHORIZATION NUMBER									
E.		F.		G.		H.		I.		J.									
I.		J.		K.		L.													
24. A. DATE(S) OF SERVICE From To		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
11 03 21 11 03 21		11				99213		a:b:c		145 00		1		NPI		555555555			
														NPI					
														NPI					
														NPI					
														NPI					
														NPI					
														NPI					
														NPI					
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use							
123456789		<input type="checkbox"/> <input checked="" type="checkbox"/>		205858191827461		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 145 00		\$ 0 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # (443)											
SIGNED				Eastern Office				Family Practice											
11/02/2021				225 Schilling Circle				225 Schilling Circle											
DATE				Hunt Valley, MD 21031				Hunt Valley, MD 21031											
a. 5555555555				b. 1234567890															
NUCC Instruction Manual available at: www.nucc.org				PLEASE PRINT OR TYPE				APPROVED OMB-0938-1197 FORM				1500 (02-12)							

In DrChrono, you can set up an office for alternative locations where you provide services to patients, including assisted living facilities, the patient's home, or skilled nursing facilities among others.

Once set up, when an appointment is scheduled in the assisted living facility, for example, the correct information will automatically populate in boxes 24A (POS), 32 (Service location), and 33 (Billing provider). DrChrono makes it very simple.

To create an office and set the applicable information, follow the steps below.

1. Hover over the **Account** and select **Offices**.
2. Select **Edit** corresponding to the office if existing, or the **+ Add New Office** button if it is not already listed.

Manage offices

Active Offices Page 1 of 1 [+ Add New Office](#)

Name Provider	Address	City	Phone	Facility Code	# Exam Rooms	Online Schedule	Sharing	Telehealth Enabled	
Primary Office	789 Main Street	Baltimore	(410) 787-1234	11	4	None But Visible To Patients	Share View	<input type="checkbox"/> OFF	History Edit Archive

3. From the **Basic** tab enter the name in the **Facility Name** field and the service location address. The name and address entered will appear in Box 32 on the HCFA 1500 form.

Edit Office

Basic **Billing** Online Schedule Providers eRx

Warning: Changing the address of an office affects all previous appointments in that office.

Office name (scheduling)

Facility name Used in HCFA box#32 and UB04 box#2.

Primary Provider

Country

Address

Zip Code

State

Canadian postal code

Canadian province

City

Office Phone

Fax

4. To change the Place of Service (POS), select the **Billing Tab** and select the code from the **Facility Code** dropdown:

If you would like the facility or another NPI to reflect on Box 32a. You will need to check the box that reads **“Use facility NPI number in box 32a of HCFA form”** and enter the NPI in the **“Facility NPI number”** field.

If the field is left blank, DrChrono will retrieve the NPI from the **Account > Provider Settings > Billing tab > Rendering NPI** field.

To input the provider number in box 32b, enter the number in the **Facility Provider Number** field. Once you have entered all information, click on **Save** at the bottom to save the changes.

Note: The facility address will reflect in the HCFA form block #32 even when the office is marked POS 13.

Edit Office

Basic **Billing** Online Schedule Providers eRx

Billing name Leave it blank if same to account settings.

Facility Code ▼

Billing Provider Office ▼ Professional medical billing only.

Use facility NPI number in box 32a of HCFA form

Facility NPI number Used in HCFA box#32a and UB04 box#56

Facility provider number

5. Next, go to **Billing > Insurance Setup**.

6. Select the pencil icon next to the insurance.

Required info for Provider

All of this info should be in the system. If it's missing we cannot submit billing for the Healthcare Provider.

Organization Name:	
Tax ID:	
Billing NPI:	
Rendering Provider NPI:	
DEA #: (optional)	
Legacy Blue Shield ID: (optional)	
Legacy Blue Cross ID: (optional)	
Legacy Medicaid ID: (optional)	

[+ Add Payer](#)

Enrollments

Payer id	Payer Name	Specialty	Proc Days	Bal Bill	Acc Assg	Group #	Indv #	Billing NPI	Eligibility NPI	Provider Name	Tax ID Number	
10211	Georgla Medicare Part A		30	No	Yes			Group NPI Number (1234567897)	Group NPI Number (1234567897)	Practice Name (None)		

7. Check the **Send Facility Provider Number** box and **Save**.

Add/Edit Payer x

<p>Payer name <input type="text"/></p> <p>Payer id <input type="text"/></p> <p>Insurance plan type <input type="text"/></p> <p>Specialty <input type="text"/></p> <p>Billing npi <input type="text"/></p> <p>Eligibility npi <input type="text"/></p> <p>Provider name <input type="text"/></p> <p>Tax id number <input type="text"/></p> <p>Group Provider # <input type="text"/></p> <p>Group provider number qualifier <input type="text"/></p> <p>Individual Provider # <input type="text"/></p> <p>Individual provider number qualifier <input type="text"/></p> <p>Balance billing <input type="text"/></p> <p>Filing limit days <input type="text"/></p> <p>Accept assignment <input checked="" type="checkbox"/></p>	<p>Send insured signature <input type="checkbox"/> Print insured person signature in box #13 in HCFA form authorizing insurance payments to billing provider</p> <p>Send facility provider number <input checked="" type="checkbox"/> Print Office Facility Provider Number in box #32b in HCFA form</p> <p>Send facility information <input type="checkbox"/></p> <p>Processing days <input type="text"/></p> <p>Referring doctor <input type="text"/></p> <p>Ordering doctor <input type="text"/></p> <p>Rendering taxonomy code <input type="text"/></p> <p>Billing taxonomy code <input type="text"/></p> <p>Payer grouping <input type="text"/></p> <p>Print license numbers in hcfa <input type="checkbox"/> Print license number on Procedures lines and box #31 in HCFA form</p> <p>Do not bill patients for balance <input type="checkbox"/></p>
--	--

Close
Save

The number will appear in box 32b for this payer.

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. CHARGES	G. DAYS OR UNITS	H. ICD-9-CM	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To			(Explain Unusual Circumstances)	POINTER					
MM	DD	YY	MM	DD	YY					
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
		<input type="checkbox"/> <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	\$ 0.00	\$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #			
Primary Office 789 Main Street Baltimore, MD 21126		a. NPI		b. 1234567890			
SIGNED		DATE		a. 1234567897		b.	

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM
1500 (02-12)

