Physical Therapy Billing Example: CMS-1500

Page updated: August 2020

The example in this section is to assist providers in billing for physical therapy services on the *CMS-1500* claim form. Refer to the *Physical Therapy* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Physical Therapy Visits

Figure 1: Physical Therapy Visits

This is a sample only. Please adapt to your billing situation.

In this example, a physical therapist is billing for an initial evaluation and subsequent therapy visits. HCPCS codes X3920 (any of the tests and measurements; initial 30 minute, plus report) and X3908 (treatment, including a combination of any modalities and procedures) are entered in the *Procedures, Services or Supplies field* (Box 24D).

Since the patient's accident/injury is not employment related, an "X" is entered in the *No* box of the *Employment* field (Box 10A). The date that the accident/injury occurred is entered in the *Date of Current Illness, Injury, or Pregnancy* field (Box 14).

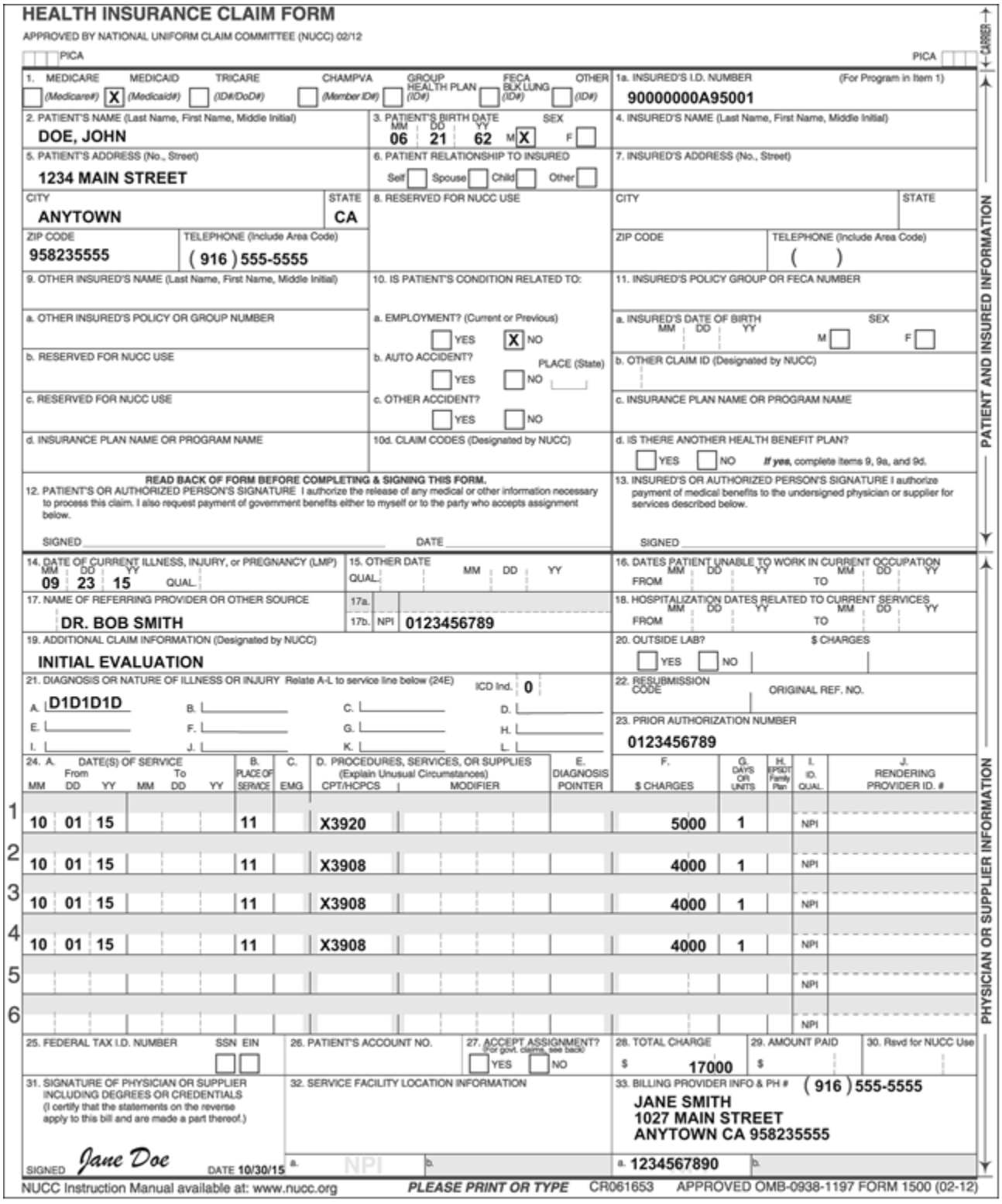
All physical therapy services require authorization. The *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23). Also, physical therapists are reimbursed for services only if the services are in response to the written prescription of licensed practitioners, acting within the scope of their practice. The referring physician's name and National Provider Identifier (NPI) are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B).

Because the physical therapist is billing for an initial evaluation, a statement saying this must be entered in the *Additional Claim Information* field (Box 19).

In this example, an ICD-10-CM code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Enter the usual and customary charges in the *Charges* field (Box 24F).

Figure 1: Physical Therapy Visits



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 23 15 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): INITIAL EVALUATION

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 0123456789

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	15			11		X3920			5000	1		NPI	
2	10	01	15			11		X3908			4000	1		NPI	
3	10	01	15			11		X3908			4000	1		NPI	
4	10	01	15			11		X3908			4000	1		NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 17000

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED Jane Doe DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.