Cardiology Billing Examples:-- CMS-1500

Page updated: August 2020

This section is to assist providers in completing the *CMS-1500* claim form for cardiology procedures. Refer to the *Cardiology* 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 examples. 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.

Transesophageal Echocardiography Professional and Technical Components Rendered by Same Provider

Figure 1. Transesophageal Echocardiography both professional and technical component services indicated by billing on one line without a modifier

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

In this example, a provider has performed a Transesophageal Echocardiography (TEE) for a recipient, and has rendered both the professional component (placement of transesophageal probe) and the technical component (image acquisition, interpretation and report) of the service. Because both components were rendered by the same provider, CPT® code 93312 is entered on a single claim line without a modifier.

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.

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 QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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			22		93312			15574			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? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 15574

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 10/02/15

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. 0123456789 b.

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

***Figure 1*:** Transesophageal Echocardiography Professional and Technical Component Services .

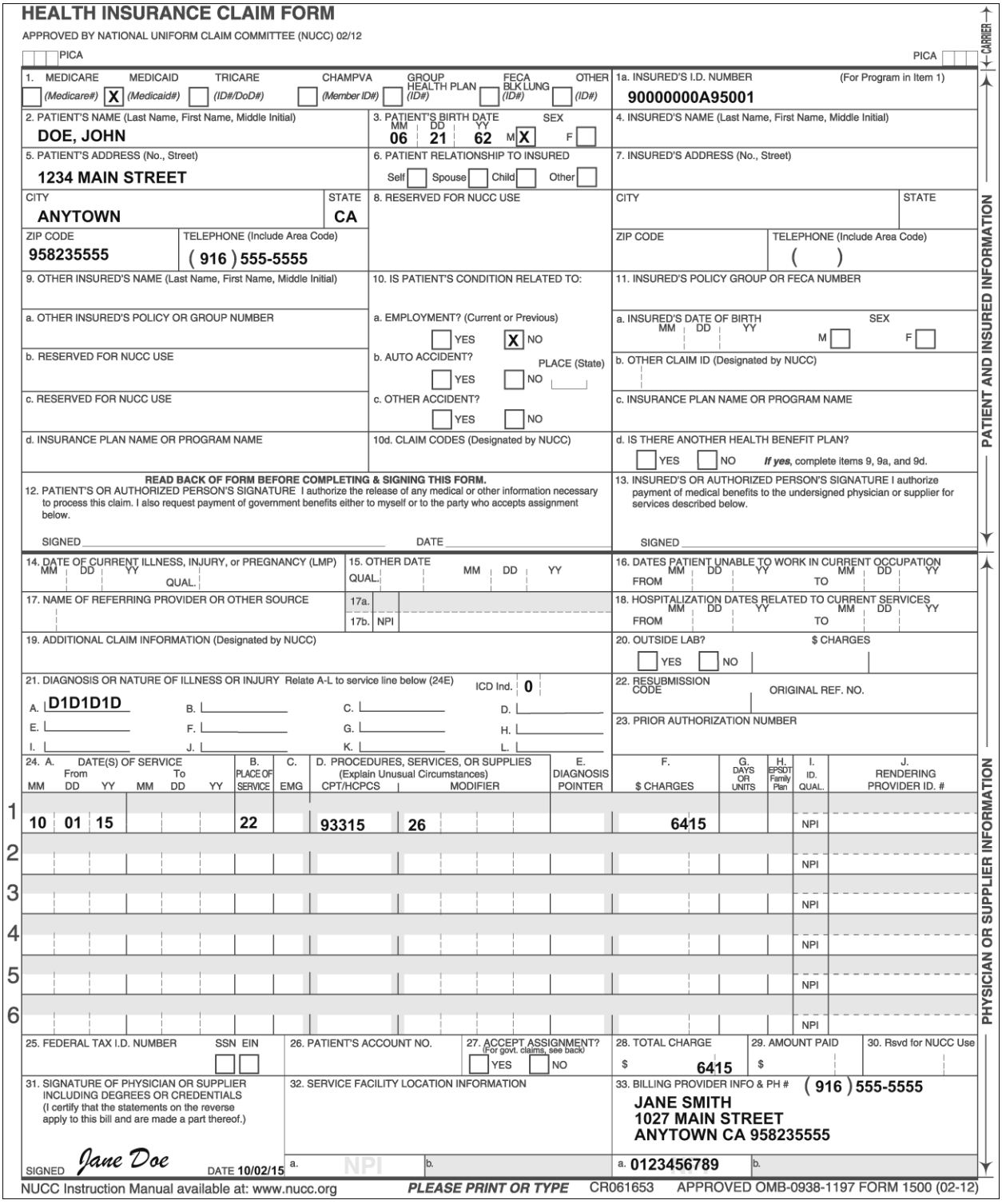
Transesophageal Echocardiography Professional Component Only

Figure 2. Transesophageal Echocardiography professional component only indicated by modifier 26.

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

In this example, a provider has performed a Transesophageal Echocardiography (TEE) for a recipient, and has rendered only the professional component of the service. This service is indicated using CPT code 93315 and modifier 26 on the claim line.

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.



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: 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 QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

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			22		93315	26		6415			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? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 6415

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 10/02/15

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. 0123456789 b.

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 2: Transesophageal Echocardiography Professional Component Service Indicated by Modifier 26

‹‹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.