Every Woman Counts Billing Examples: CMS-1500

Page updated: August 2020

Examples in this section are to assist providers in billing for Every Woman Counts services on the CMS-1500 claim form. Refer to the Every Woman Counts 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.

Billing for Case Management Following Provision of Breast or Cervical Cancer Screening Services

Figure 1: Billing for annual case management.

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

The recipient ID number (which is computer generated after the online Recipient Information form is completed and submitted) is entered in the Insured's ID Number field (Box 1a).

When submitting a claim for case management, an ICD-10-CM diagnosis code is required 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.

See "Approved Procedures" in the Every Woman Counts section of this manual for a listing of relevant ICD-10-CM diagnosis codes. Only cycles with findings that require immediate work-up and additional referrals and coordination of services are eligible for claim submission for case management. HCPCS code T1017 is used to bill for this service. This service is payable only to the Primary Care Provider (PCP).

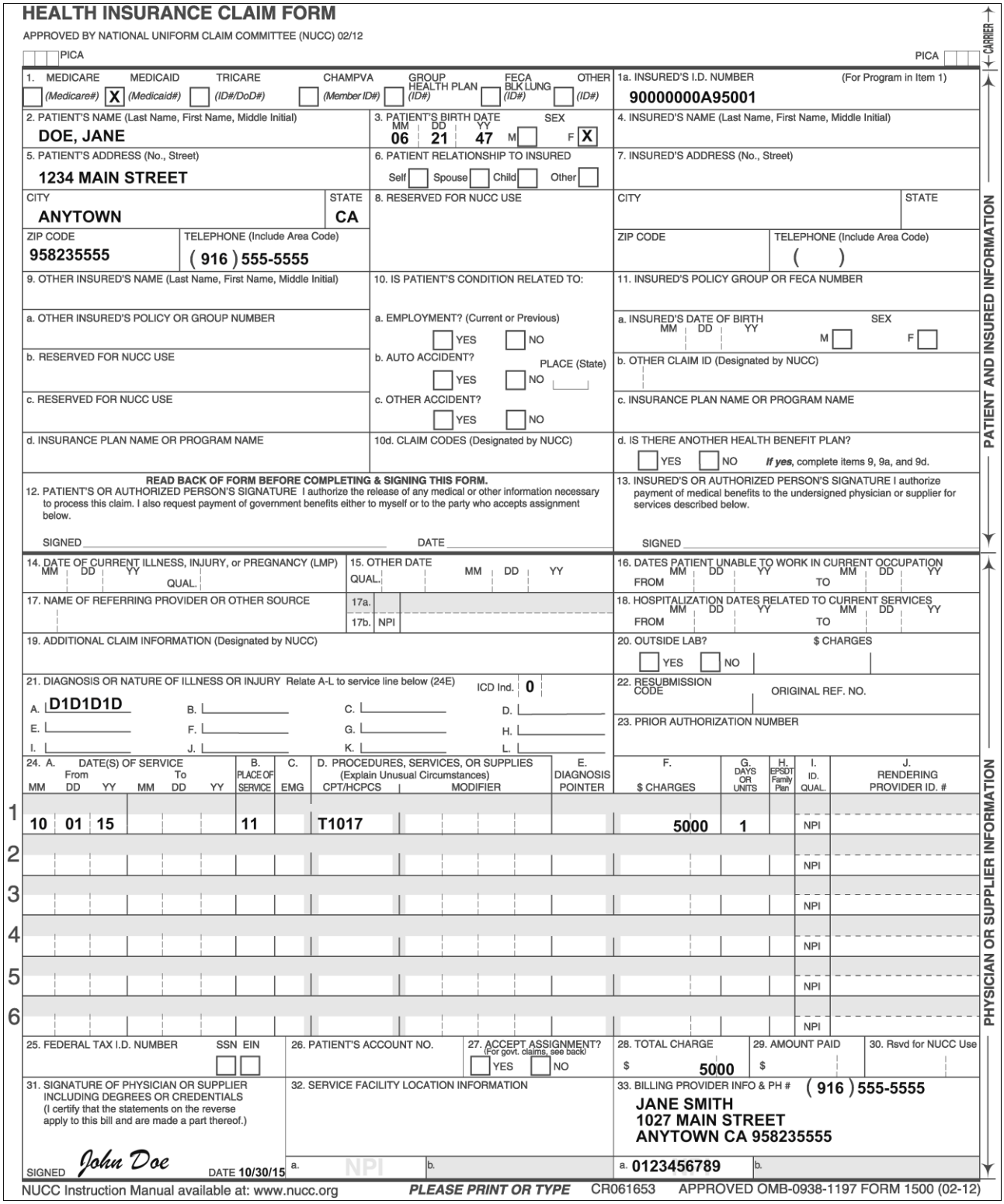
A case management HCPCS code is entered in the Procedures, Services or Supplies field, Box 24D. To qualify to bill this case management fee, the recipient's PCP is required to have submitted clinical information using the online breast/cervical cancer screening cycle data forms.

Note: PCPs are reimbursed for case management only when they have completed all required screening and follow-up services and forms within the recipient's active eligibility period. Case management will be paid once per recipient, per provider, per calendar year.

Enter the usual and customary charges in the Charges field (Box 24F). Enter a "1" in the Days or Units field (Box 24G) for each claim line.

Providers should enter the billing provider's address and phone number in the Billing Provider Info and Phone Number field (Box 33) and an NPI number in NPI field (Box 33a).

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be paid correctly.



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, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 47 SEX M [ ] F [X]

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 [ ]

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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			11		T1017			5000	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? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 5000

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 John 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. 0123456789 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1. Breast and Cervical Cancer Screening Billed With Annual Case Management.

‹‹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.