

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## Acupuncture Services Billing Example: CMS-1500

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The example in this section is to assist providers in billing for acupuncture services on the *CMS-1500* claim form. Refer to the *Acupuncture Services* 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-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**Multiple Acupuncture  
Visits**

*Figure 1. Multiple acupuncture visits.*

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

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* field (Box 14).

As a requirement for billing acupuncture services, the diagnosis of the condition causing the pain, other treatments given and the results of other treatments must be submitted with each claim; therefore, a statement and "See attached documentation" are entered in the *Reserved for Local Use* field (Box 19).

In this example, ICD-9-CM code 726.10 (disorders of bursae and tendons in shoulder region, unspecified rotator cuff syndrome) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

An acupuncturist is billing for services provided on different dates of service (June 11 and June 21, 2007). CPT-4 codes 97810 and 97811 (one or more needles, without electrical stimulation) and 97813 and 97814 (one or more needles, with electrical stimulation) are entered in the *Procedures, Services or Supplies* field (Box 24D) in the lower portion of the field. Each code must be on a separate line in order for providers to be correctly reimbursed.

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

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>90000000A95001</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN</b>				3. PATIENT'S BIRTH DATE MM   DD   YY SEX <b>06   21   62 M <input checked="" type="checkbox"/> F <input type="checkbox"/></b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY <b>ANYTOWN</b>		STATE <b>CA</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE <b>95823</b>		TELEPHONE (Include Area Code) <b>(916) 555-5555</b>		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
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.					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 _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM   DD   YY <b>05   21   07</b>				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY					
19. RESERVED FOR LOCAL USE <b>FIRST VISIT/SUBSEQUENT VISIT. SEE ATTACHED DOCUMENTATION FOR A LIST OF PREVIOUS TREATMENTS/RESULTS.</b>											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>72610</b>					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
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 <b>06   11   07</b>		<b>11</b>	<b>97810</b>				<b>5000</b>	<b>1</b>			
2 <b>06   11   07</b>		<b>11</b>	<b>97811</b>				<b>5000</b>	<b>1</b>			
3 <b>06   21   07</b>		<b>11</b>	<b>97813</b>				<b>4000</b>	<b>1</b>			
4 <b>06   21   07</b>		<b>11</b>	<b>97814</b>				<b>4000</b>	<b>1</b>			
5											
6											
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (If gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>18000</b>		29. AMOUNT PAID \$	30. BALANCE DUE \$ <b>18000</b>
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.)  <i>Jane Doe</i> SIGNED _____ DATE <b>06/30/07</b>				32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b.				33. BILLING PROVIDER INFO & PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b> a. <b>0123456789</b> b.			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

Figure 1. Multiple Acupuncture Visits.