

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

preg ex cms

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## Pregnancy Examples: CMS-1500

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Examples in this section are to help providers bill for pregnancy services on the *CMS-1500* claim form. Refer to the Pregnancy sections 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-9-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.

**Per-Visit Billing of a Vaginal Delivery and Antepartum Office Visit**

*Figure 1. Per-Visit Billing of a Vaginal Delivery and Antepartum Office Visit.*

HCPCS code Z1034 (per-visit antepartum office visit) and CPT-4 code 59409 (per-visit vaginal delivery) with AG modifier (indicating the provider is the primary surgeon) are entered in the *Procedures, Services, or Supplies* field (Box 24D).

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code V22.0 represents supervision of a normal first pregnancy.

In the *Date(s) of Service* field (Box 24A), the date of the office visit, August 9, 2015 is entered on claim line 1 as 080915. The August 20, 2015 date of the vaginal delivery (CPT-4 code 59409) is entered on claim line 2 as 082015. Enter Place of Service codes for each claim line in Box 24B. In this case, “11” (office) for the antepartum visit and “21” (inpatient hospital) for the delivery.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both Z1034 and 59409.

**Note:** Delivery services performed in an inpatient setting must be billed on a *CMS-1500*. The physician’s billing information is entered in the *Billing Provider Information and Phone #* field (Box 33). The physician’s NPI is entered in Box 33A.

HEALTH INSURANCE CLAIM FORM																											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12																											
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																	
1. MEDICARE <input type="checkbox"/> (Medicare#)			MEDICAID <input checked="" type="checkbox"/> (Medicaid#)			TRICARE <input type="checkbox"/> (ID#/DoD#)			CHAMPVA <input type="checkbox"/> (Member ID#)			GROUP HEALTH PLAN <input type="checkbox"/> (ID#)			FECA BLK LUNG <input type="checkbox"/> (ID#)			OTHER <input type="checkbox"/> (ID#)			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, JANE</b>						3. PATIENT'S BIRTH DATE MM DD YY <b>06 12 76</b>			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			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. RESERVED FOR NUCC USE						CITY			STATE												
ZIP CODE <b>958235555</b>				TELEPHONE (Include Area Code) <b>( 916 ) 555-5555</b>								ZIP CODE			TELEPHONE (Include Area Code) <b>( )</b>												
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. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						b. OTHER CLAIM ID (Designated by NUCC)															
c. RESERVED FOR NUCC USE						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. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>															
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 MM DD YY QUAL: _____						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY <b>08 20 15 TO 08 21 15</b>															
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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b> A. <b>V220</b> 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. EPOSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #							
1 <b>08 09 15</b>		<b>11</b>				<b>Z1034</b>						<b>100 00</b>		<b>1</b>				<b>NPI</b>									
2 <b>08 20 15</b>		<b>21</b>				<b>59409 AG</b>						<b>89 00</b>		<b>1</b>				<b>NPI</b>									
3																		<b>NPI</b>									
4																		<b>NPI</b>									
5																		<b>NPI</b>									
6																		<b>NPI</b>									
25. FEDERAL TAX I.D. NUMBER				SSN EIN <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ <b>189 00</b>				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 <i>Jane Doe</i> DATE <b>08/30/15</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. _____									

Figure 1. Per-Visit Billing of a Vaginal Delivery and Antepartum Office Visit.

**Multiple Births: Claims for Twins A and B Using Mom's Medi-Cal ID Number***Figures 2 and 3. Multiple Births: Claims for Twin A and Twin B Using Mom's Medi-Cal ID Number.*

A mother, who is admitted to the hospital on April 1, 2015, delivers twins the same day. The preceding claim (*Figure 1*) shows how to bill for the mother's vaginal delivery on a per-visit basis. The next two examples show how to bill normal newborn care services for the healthy twins. (When billing for care of multiple newborns, complete Boxes 1A, 2, 3, 4 and 6.)

Enter the mother's Medi-Cal ID Number as it appears on the Benefits Identification Card (BIC) in the *Insured's ID Number* field (Box 1A). (Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.)

Enter the babies' names in the *Patient's Name* field (Box 2). If the infants have not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl." Each baby from a multiple birth must also be designated by a number or letter (example: Jones Baby Girl Twin A).

Enter the infant's sex and date of birth in the *Patient's Birth Date/Sex* field (Box 3). Enter the mother's name in Box 4 (*Insured's Name*). Check the *Child* box in Box 6 (*Patient's Relationship to Insured*).

To facilitate payment of the claim, enter the words "NEWBORN USING MOTHER'S ID TWIN A (OR B)" in the *Additional Claim Information* field (Box 19). Providers may also wish to use the *Patient's Account Number* field (Box 26) to enter Twin A (or B). This is not a required field, but it is for provider convenience. This field is repeated in all payment information (such as the *Remittance Advice Details [RAD]*), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code V31.00 represents twins, born in a hospital, "without mention of cesarean delivery." The ICD-9-CM code is entered on the claim as V3100.

In the *Date(s) of Service* field (Box 24A), enter the date that the newborn care service was rendered. April 1, 2015 is entered on claim line 1 as 040115. Enter the Place of Service code in Box 24B. In this case code "21" represents inpatient hospital.

Claim for Twin A:

Enter CPT-4 code 99460 (initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant) in the *Procedures, Services or Supplies* field (Box 24D). Normal newborn care is billed with code 99460 for the first day of care. CPT-4 code 99462 (subsequent hospital care, for the evaluation and management of a normal newborn) is billed on separate claim lines, as shown.

Claim for Twin B:

The claim for twin B is billed the same as for twin A except that modifier 25 (significant, separately identifiable Evaluation and Management service by the same physician on the day of a procedure) is added to each claim line so the claim will not deny for National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs). Refer to the *Correct Coding Initiative: National* section in this manual for information about NCCI and MUEs.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both codes 99460 and 99462.

In this case, the same doctor who delivers the babies also examines both twins. Therefore, the same NPI used for the mother (in this case 0123456789) is entered in the *Billing Provider Info & Phone #* field (Box 33).

**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 reimbursed correctly.

Other Physician  
Examines Infants

In many cases, a physician other than the delivering physician examines the newborn(s). In such instances, the name, address, telephone number and NPI of the physician who examines the infants is entered in Box 33 and 33A and modifier 25 is unnecessary for that claim line.

HEALTH INSURANCE CLAIM FORM										
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12										
PICA <input type="checkbox"/>					PICA <input type="checkbox"/>					
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK/LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9000000A95001</b>					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE BABY GIRL TWIN A</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>04 01 15</b> SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE, JANE</b>			
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 checked="" type="checkbox"/> Other <input type="checkbox"/>					
CITY <b>ANYTOWN</b>			STATE <b>CA</b>		CITY			STATE		
ZIP CODE <b>958235555</b>			TELEPHONE (Include Area Code) <b>(916) 555-5555</b>		ZIP CODE			TELEPHONE (Include Area Code) <b>( )</b>		
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 M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE					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. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
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 MM DD YY QUAL.		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. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
17b. NPI _____					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>NEWBORN INFANT USING MOTHER'S ID TWIN A</b>					22. RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b>					23. PRIOR AUTHORIZATION NUMBER					
A. <b>V3100</b> B. _____ C. _____ D. _____					F. \$ CHARGES					
E. _____ F. _____ G. _____ H. _____					G. DAYS OR UNITS					
I. _____ J. _____ K. _____ L. _____					H. EPICOT Family Plan					
I. ID. QUAL.					J. RENDERING PROVIDER ID. #					
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					
1 <b>04 01 15</b> <b>21</b> <b>99460</b>					<b>50.00 1</b> NPI					
2 <b>04 02 15</b> <b>21</b> <b>99462</b>					<b>50.00 1</b> NPI					
3 <b>04 03 15</b> <b>21</b> <b>99462</b>					<b>50.00 1</b> NPI					
4					NPI					
5					NPI					
6					NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. <b>TWIN A</b>		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>150.00</b>	
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 <i>Jane Doe</i> DATE <b>04/15/15</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. _____										

Figure 2. Multiple Births: Claim for Twin A Using Mom's Medi-Cal ID Number

HEALTH INSURANCE CLAIM FORM																				
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12																				
PICA <input type="checkbox"/>					PICA <input type="checkbox"/>															
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9000000A95001</b>															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE BABY GIRL TWIN B</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>04 01 15</b>		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>DOE, JANE</b>										
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 checked="" type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)										
CITY <b>ANYTOWN</b>			STATE <b>CA</b>		8. RESERVED FOR NUCC USE					CITY		STATE								
ZIP CODE <b>958235555</b>			TELEPHONE (Include Area Code) <b>(916) 555-5555</b>							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 M F										
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)										
c. RESERVED FOR NUCC USE					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. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.										
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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL					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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>NEWBORN INFANT USING MOTHER'S ID TWIN B</b>										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b>										22. RESUBMISSION CODE ORIGINAL REF. NO.										
A. <b>V3100</b> B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER										
E. _____ F. _____ G. _____ H. _____										F. \$ CHARGES										
I. _____ J. _____ K. _____ L. _____										G. DAYS OR UNITS		H. EP/SBT Family Plan		I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
24. A. DATE(S) OF SERVICE		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. EP/SBT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From MM DD To YY		MM DD				99460 25					50.00 1		1		NPI					
04 01 15		21				99462 25					50.00 1		1		NPI					
04 02 15		21				99462 25					50.00 1		1		NPI					
04 03 15		21				99462 25					50.00 1		1		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) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>150.00</b>		29. AMOUNT PAID \$		30. Rsvd for NUCC Use				
					<b>TWIN B</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>					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b>										
SIGNED _____					DATE <b>04/15/15</b>					a. <b>NPI</b>		b. <b>0123456789</b>								

Figure 3. Multiple Births: Claim for Twin B Using Mom's Medi-Cal ID Number.

**Per-Visit Billing of C-Section and Postpartum Office Visit**

*Figure 4. Per-Visit Billing of Cesarean Section Delivery and Postpartum Office Visit.*

CPT-4 code 59514 (per-visit cesarean section delivery) with AG modifier (indicating the provider is the primary surgeon) and HCPCS code Z1038 (per-visit postpartum visit) are entered in the *Procedures, Services or Supplies* field (Box 24D).

In this example, ICD-9-CM code V22.0 representing supervision of a normal first pregnancy is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21, Number 1). This is the primary diagnosis. ICD-9-CM code 762.5 (other compression of umbilical cord) is entered as the secondary diagnosis code to support the need for a cesarean section.

In the *Date(s) of Service* field (Box 24A), the date of the cesarean section, June 20, 2015, is entered on claim line 1 as 062015. The date of service for the postpartum office visit, July 10, 2015 is entered on claim line 2 as 071015. Enter Place of Service codes “21” (inpatient hospital) and “11” (office) on the appropriate claim lines in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both 59514 and Z1038.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES											
										<input type="checkbox"/> YES <input type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE		ORIGINAL REF. NO.											
A. <b>V220</b> B. <b>7625</b> C. _____      D. _____ E. _____      F. _____      G. _____      H. _____ I. _____      J. _____      K. _____      L. _____										ICD Ind. <b>9</b>													
24. A. DATE(S) OF SERVICE										D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From			To			B. PLACE OF SERVICE		C. EMG		D. CPT/HCPCS		D. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY																		
1	06	20	15			21				59514	AG			48064	1					NPI			
2	07	10	15			11				Z1038				5340	1					NPI			
3																				NPI			
4																				NPI			

*Figure 4. Per-Visit Billing of Cesarean Section Delivery and Postpartum Office Visit.*

**Per-Visit Billing of Antepartum Office Visit and Ultrasound**

Figure 5. Per-Visit Billing of Antepartum Office Visit and Ultrasound.

HCPCS code Z1034 for per-visit antepartum visit and SB modifier (indicating service was rendered by a Nurse Midwife) are entered in the *Procedures, Services or Supplies* field (Box 24D). Also entered in this field, on the next claim line, is CPT-4 code 76805 for ultrasound service without a modifier, indicating the provider is submitting a claim for both the technical and professional components of the ultrasound service.

ICD-9-CM diagnosis code V28.0 (guide for amniocentesis) is included in the *Diagnosis or Nature of Illness or Injury* field (Box 21) to justify the need for ultrasound.

In the *Date(s) of Service* field (Box 24A), the date of the office visit, August 9, 2015 is entered on claim line 1 as 080915. The August 12, 2015 date for ultrasound is entered on claim line 2 as 081215. Both the procedures were performed in an office so “11” (office) is placed in Box 24B for both claim lines.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both Z1034 and 76805.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											20. OUTSIDE LAB?		\$ CHARGES		
<b>LINE 1: CNM MARTHA LOWE LICE 456132 LINE 2: SEE ATTACH. FOR ULTRASOUND JUSTIF.</b> 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b>											<input type="checkbox"/> YES <input type="checkbox"/> NO				
A. <b>V280</b> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											22. RESUBMISSION CODE		ORIGINAL REF. NO.		
24. A. DATE(S) OF SERVICE											23. PRIOR AUTHORIZATION NUMBER				
From			To			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPBDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER						
1	08	09	15			11		Z1034	SB		100.00	1		NPI	
2	08	12	15			11		Z76805			200.00	1		NPI	
3														NPI	
4														NPI	

Figure 5. Per-Visit Billing of Antepartum Office Visit and Ultrasound.

**Internal Fetal Monitor Billed With Modifier 99**

Figure 6. Internal Fetal Monitor Billed With Modifier 99.

CPT-4 code 59051 (fetal monitoring during labor by consulting physician with written report; interpretation only) with required modifier 99 are entered in the *Procedures, Services or Supplies* field (Box 24D). Code 59051 is reimbursable only with modifier 99, which, in this case, requires that the words "INDEPENDENT PROCEDURE" be included in the *Additional Claim Information* field (Box 19). Also required in this field is the date of delivery.

In this example, ICD-9-CM code 763.4 (cesarean delivery) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21, Number 1). This is the primary diagnosis. ICD-9-CM code 762.5 (other compression of umbilical cord) is entered as the secondary diagnosis code to support the need for a cesarean section.

In the Date(s) of Service field (Box 24A), the date that the internal fetal monitoring was performed, June 21, 2015, is entered on claim line 1 as 062115. Enter Place of Service code "21" (inpatient hospital) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the Days or Units field (Box 24G) for 59051.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>DELIVERY DATE: 062015 MODIFIER 99 = INDEPENDENT PROCEDURE</b>										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b>										22. RESUBMISSION CODE		ORIGINAL REF. NO.	
A. <b>7634</b> B. <b>7625</b> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From To 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. IEP/SDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										OR SUPPLIER INFORMATION			
1   06   21   15       21     59051   99       74.48   1       NPI													
2													
3													
4													

Figure 6. Internal Fetal Monitor Billed With Modifier 99.

**Global Billing of C-Section  
With Tubal Ligation**

*Figure 7. Global Billing of Cesarean Delivery With Tubal Ligation.*

CPT-4 code 59510 (global cesarean section delivery) with AG modifier (indicating the provider is the primary surgeon) and code 58611 (tubal ligation) with modifier 51 (in this case, special circumstance) are entered in the *Procedures, Services or Supplies* field (Box 24D).

The C-section service rendered in connection with this claim is being billed globally and therefore the claim must be billed in the "from-through" format. The "from" date of service for code 59510 is the first date the recipient was seen for the pregnancy. In this case, January 14, 2014 is entered as "011414" on claim line 1 as the "from" date. The "through" or "to" date of service (October 15, 2014), which is the date of the delivery, is entered in the "through" column as 101514. Because the tubal ligation service was performed with the C-Section delivery, the same date (October 15, 2014) is entered in the "From" and "To" columns of the *Date(s) of Service* field (Box 24A) for code 58611.

Enter the date of the Last Menstrual Period (LMP) in the *Date of Current Illness, Injury, or Pregnancy (LMP)* field (Box 14).

Physicians must use:

- Modifier AG (primary physician) to bill for the C-section or intra-abdominal surgery
- Modifier 51 to bill the tubal ligation (CPT-4 code 58611)
- A sterilization *Consent Form* (PM 330)

In order to bill globally, the dates of the eight antepartum visits must be entered in the *Additional Claim Information* field (Box 19).

In *Figure 7*, on the following page, ICD-9-CM code V22 representing a normal first pregnancy is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21, Number 1). This is the primary diagnosis. ICD-9-CM code V25.2 (sterilization) is entered as the secondary diagnosis code and represents the tubal ligation. The *ICD-9-CM International Classification of Diseases* code book explains that code V25.2 is “admission to the hospital for interruption of the fallopian tubes...”

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both 59510 and 58611.

**Note:** Assistant Surgeons must bill CPT-4 code 59514 with modifier 80 and code 58611 with modifier 99. The *Additional Claim Information* field (Box 19) of the *CMS-1500* must note that modifier 99 was used to signify “modifier 80 and modifier 51.”

Delivery services performed in an inpatient setting must be billed on a CMS-1500 claim using the physician’s NPI. The NPI is entered in Box 33A.

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9000000A95001</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE, JANE</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>06 12 86</b> SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>				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>	6. RESERVED FOR NUCC USE				CITY		STATE	
ZIP CODE <b>958235555</b>			TELEPHONE (Include Area Code) <b>(916) 555-5555</b>					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 M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE				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. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
<p align="center"><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> <p>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.</p>											
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 <b>12 04 13</b> QUAL.				15. OTHER DATE QUAL. 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. _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
17b. NPI								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>ANTEPARTUM VISITS: 07/09/14, 07/23/14, 08/13/14, 09/03/14, 09/17/14, 09/24/14, 10/01/14, 10/08/14</b>											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>9</b>											
A. <b>V22</b>			B. <b>V252</b>			C. _____			D. _____		
E. _____			F. _____			G. _____			H. _____		
I. _____			J. _____			K. _____			L. _____		
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	
1 <b>01 14 14 10 15 14 21</b>		<b>14 21</b>		<b>59510 AG</b>		<b>1200 00</b>		NPI			
2 <b>10 15 14 10 15 14 21</b>		<b>14 21</b>		<b>58611 51</b>		<b>400 00</b>		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) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>1600 00</b>	
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.)  <i>Jane Doe</i>					
32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b>					
SIGNED <i>Jane Doe</i> DATE <b>10/20/14</b>				a. <b>NPI</b>		b. _____		a. <b>0123456789</b>		b. _____	

Figure 7. Global Billing of Cesarean Delivery With Tubal Ligation.