

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

Psychological Services: Billing Examples

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Examples in this section are to assist providers in billing for psychological services on the *CMS-1500* claim form. Refer to the *Psychological 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 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 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 Therapy Sessions

Figure 1. Multiple Therapy Sessions.

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

In this example, a psychologist is billing for two separate therapy sessions. CPT-4 code 90837 (psychotherapy, 60 minutes with recipient and/or family member) is entered in the *Procedures, Services or Supplies* field (Box 24D) for each date of service.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that services were rendered in an office. Enter the usual and customary charges in the *Charges* field (Box 24F) and a "1" in the *Days or Units* field (Box 24G) to indicate that one office visit was made for each date of service.

<p>1500</p> <p>HEALTH INSURANCE CLAIM FORM</p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>											
<p>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"/></p> <p>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</p>											
<p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p>DOE JOHN</p>						<p>3. PATIENT'S BIRTH DATE</p> <p>MM DD YY 06 21 62 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/></p>					
<p>5. PATIENT'S ADDRESS (No., Street)</p> <p>1234 MAIN STREET</p>						<p>6. PATIENT RELATIONSHIP TO INSURED</p> <p>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p>					
<p>CITY ANYTOWN STATE CA</p>				<p>8. PATIENT STATUS</p> <p>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>				<p>7. INSURED'S ADDRESS (No., Street)</p>			
<p>ZIP CODE 95823 TELEPHONE (Include Area Code) (916) 555-5555</p>				<p>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></p>				<p>ZIP CODE () TELEPHONE (Include Area Code) ()</p>			
<p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>						<p>10. IS PATIENT'S CONDITION RELATED TO:</p>					
<p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p>						<p>a. EMPLOYMENT? (Current or Previous)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>b. OTHER INSURED'S DATE OF BIRTH</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>						<p>b. AUTO ACCIDENT? PLACE (State)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>c. EMPLOYER'S NAME OR SCHOOL NAME</p>						<p>c. OTHER ACCIDENT?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p>						<p>10d. RESERVED FOR LOCAL USE</p>					
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</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> <p>SIGNED _____ DATE _____</p>						<p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p> <p>90000000A95001 (For Program in Item 1)</p>					
<p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</p> <p>MM DD YY 01 03 14</p>						<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE</p> <p>MM DD YY 01 17 14</p>					
<p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p>						<p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p> <p>FROM MM DD YY TO MM DD YY</p>					
<p>19. RESERVED FOR LOCAL USE</p>						<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</p> <p>FROM MM DD YY TO MM DD YY</p>					
<p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</p> <p>1. _____ 3. _____</p> <p>2. _____ 4. _____</p>						<p>20. OUTSIDE LAB? \$ CHARGES</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</p> <p>B. PLACE OF SERVICE</p> <p>C. EMG</p> <p>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER</p> <p>E. DIAGNOSIS POINTER</p>						<p>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</p> <p>23. PRIOR AUTHORIZATION NUMBER</p>					
<p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p>						<p>26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see b340)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>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.)</p> <p><i>Jane Doe</i></p>						<p>28. TOTAL CHARGE \$ 10000 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 100.00</p>					
<p>SIGNED _____ DATE 01/20/14</p>						<p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI b. _____</p>					
<p>33. BILLING PROVIDER INFO & PH # (916) 555-5555</p> <p>JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555</p>						<p>a. 0123456789 b. _____</p>					
<p>NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>											

Figure 1. Multiple Therapy Sessions.