

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

Speech Therapy Billing Example: CMS-1500

speech exc
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The example in this section is to assist providers in billing for speech therapy services on the *CMS-1500* claim form. Refer to the *Speech Therapy* 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-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.

Out of Office Visit

Figure 1. Out of Office Visit.

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

In this example, a speech pathologist is billing for speech therapy services and an out of office call; therefore, “31” is entered in the *Place of Service* field (Box 24B) indicating that services were rendered at a Skilled Nursing Facility (NF) Level A or B.

HCPCS codes X4304 (speech language therapy, individual, 1/2 hour) and X4306 (out of office call) are entered in the *Procedures, Services or Supplies* field (Box 24D).

The referring physician’s name and NPI are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written referral from a licensed practitioner is required for speech therapy services.

Speech therapy services rendered to NF-A or NF-B recipients require prior authorization. The *Treatment Authorization Request (TAR)* number is entered in the *Prior Authorization Number* field (Box 23).

For this example, ICD-9-CM code 784.3 (aphasia) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21) and the usual and customary charges are entered in the *Charges* field (Box 24F).

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> <h2 style="margin: 0;">HEALTH INSURANCE CLAIM FORM</h2> <p style="font-size: small; margin: 0;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>												
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 <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) 90000000A95001						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN						3. PATIENT'S BIRTH DATE MM DD YY 06 21 62			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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			
CITY ANYTOWN			STATE CA			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			
ZIP CODE 95823			TELEPHONE (Include Area Code) (916) 555-5555			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> Student <input type="checkbox"/>			ZIP CODE			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO						
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						
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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				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 DR. BOB SMITH						17a. _____ 17b. NPI 0123456789			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 7843						23. PRIOR AUTHORIZATION NUMBER 01234567890						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. EP007 Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 06 01 07		31	X4304		_____	30 00	1	_____	_____	_____	_____	
2 06 01 07		31	X4306		_____	75 00	1	_____	_____	_____	_____	
3 _____		_____	_____		_____	_____	_____	_____	_____	_____	_____	
4 _____		_____	_____		_____	_____	_____	_____	_____	_____	_____	
5 _____		_____	_____		_____	_____	_____	_____	_____	_____	_____	
6 _____		_____	_____		_____	_____	_____	_____	_____	_____	_____	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (If gov. claims, see b490) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 105 00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 105 00
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 06/30/07						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. 1234567890 b. _____			
NUCC Instruction Manual available at: www.nucc.org												

Figure 1. Out of Office Visit.