

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

Audiological Services Billing Example: CMS-1500

audio exc

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The example in this section is to assist providers in billing for audiological services on the *CMS-1500* claim form. Refer to the *Audiological 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.

Audiological Services

Figure 1. Audiological Services.

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

In this example, an audiologist is billing for audiological services. HCPCS codes X4500 (diagnostic audiological evaluation, including pure tone audiometry, speech reception threshold and discrimination), X4526 (hearing therapy, individual, one hour) and X4530 (impedance audiometry – bilateral) are entered in the *Procedures, Services or Supplies* field (Box 24D). Only one Medi-Service reservation is required since all three services were rendered on the same date of service.

The referring physician's name and NPI number 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 audiological services.

Because the procedures being billed are part of a hearing aid evaluation, the statement "hearing aid evaluation" must be entered in the *Reserved for Local Use* field (Box 19).

In this example, ICD-9-CM code 389.1 (sensorineural hearing loss) 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> <h3 style="margin: 0;">HEALTH INSURANCE CLAIM FORM</h3> <p style="font-size: small; margin: 0;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>											
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE 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 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F			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 Student <input type="checkbox"/> Part-Time 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? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					
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					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE HARRIS BROWN, MD						17a. _____ 17b. NPI 0123456789			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
19. RESERVED FOR LOCAL USE HEARING AID EVALUATION						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3891						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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPDOT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER					
1 06 09 07 11 X4500 8500 1 NPI						25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 12345 27. ACCEPT ASSIGNMENT? (For gov. claims, see b3a3) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 17300 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 17300					
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.					

Figure 1. Audiological Services.