

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

Cardiology Billing Examples: CMS-1500

This section is to assist providers in completing the *CMS-1500* claim form for cardiology procedures. Refer to the *Cardiology* 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.

**Transesophageal
Echocardiography
Professional and Technical
Components Rendered by
Same Provider**

Figure 1. Transesophageal Echocardiography both professional and technical component services indicated by billing on one line without a modifier

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

In this example, one provider has performed a transesophageal echocardiography (TEE) for a recipient, and has rendered both the professional component (placement of transesophageal probe) and the technical component (image acquisition, interpretation and report) of the service. Because both components were rendered by the same provider, CPT-4 code 93312 is entered on a single claim line without a modifier.

HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
PICA										PICA		
1. MEDICARE (Medicare#) <input type="checkbox"/>	MEDICAID (Medicaid#) <input checked="" type="checkbox"/>	TRICARE (ID#/DoD#) <input type="checkbox"/>	CHAMPVA (Member ID#) <input type="checkbox"/>	GROUP HEALTH PLAN (ID#) <input type="checkbox"/>	FECA BLK LUNG (ID#) <input type="checkbox"/>	OTHER (ID#) <input type="checkbox"/>	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 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	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. RESERVED FOR NUCC USE				CITY		STATE		
ZIP CODE 958235555		TELEPHONE (Include Area Code) (916) 555-5555			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. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				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>				
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, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9												
A. 4241	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	G. DAYS OR UNITS	H. EPSTD Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 03 15		22		93312				15574			NPI	
2											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) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 15574	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 a. NPI				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.				
SIGNED _____ DATE 09/01/15												

Figure 1. Transesophageal Echocardiography Professional and Technical Component Services

**Transesophageal
Echocardiography
Professional
Component Only**

Figure 2. Transesophageal Echocardiography professional component only indicated by modifier 26.

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

In this example, a provider has performed a Transesophageal Echocardiography (TEE) for a recipient, and has rendered only the professional component of the service. This service is indicated using CPT-4 code 93315 and modifier 26 on the 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"/> 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) 9000000A95001						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN					3. PATIENT'S BIRTH DATE MM DD YY 06 21 62 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		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"/>						
CITY ANYTOWN			STATE CA		7. INSURED'S ADDRESS (No., Street)			8. RESERVED FOR NUCC USE			
ZIP CODE 958235555		TELEPHONE (Include Area Code) (916) 555-5555			CITY		STATE				
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 checked="" type="checkbox"/> NO						
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)						
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						
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 _____	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9											
A. 4241		B. _____		C. _____		D. _____		E. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
E. _____		F. _____		G. _____		H. _____		I. _____		23. PRIOR AUTHORIZATION NUMBER	
I. _____		J. _____		K. _____		L. _____		F. \$ CHARGES		G. DAYS OR UNITS	
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		H. ICD ID QUAL	
1 08 03 15		22		93315		26		6415		J. RENDERING PROVIDER ID. #	
2										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 gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 6415	
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 # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555					
SIGNED <i>Jane Doe</i>			DATE 08/01/15			a. NPI			b. 0123456789		

Figure 2. Transesophageal Echocardiography Professional Component Service Indicated by Modifier 26.