

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

Chiropractic Services Billing Example: CMS-1500

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

Chiropractic Visit

Figure 1. Chiropractic Visit.

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

In this example, a chiropractor is billing for an office visit. CPT-4 code 98940 (a chiropractic manipulative treatment [CMT]; spinal, one to two regions) is entered in the *Procedures, Services or Supplies* field (Box 24D).

An "X" is entered in the "No" box of the *Employment* field (Box 10A) indicating that the accident/injury is not employment related. The date of injury is entered in the *Date of Current* field (Box 14).

Also in the example, ICD-9-CM code 839.02 (second cervical vertebra closed) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a "1" in the *Days or Units* field (Box 24G) for CPT-4 code 98940 to indicate that one office visit was made on the date of service.

1500 HEALTH INSURANCE CLAIM FORM																				
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05																				
PICA																				
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE 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 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		STATE											
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		TELEPHONE (Include Area 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 checked="" 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															
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) 04 21 07			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			17a. _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE			17b. NPI _____			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 83902					22. MEDICAID 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 EMG C. 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			06 17 07			11			98940			2500			1			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? (If gov. claims, see b330) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 2500			29. AMOUNT PAID \$			30. BALANCE DUE \$ 2500		
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> SIGNED _____ 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. 0123456789 b. _____										

Figure 1. Chiropractic Visit.