

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

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Every Woman Counts Billing Examples: CMS-1500

Examples in this section are to assist providers in billing for Every Woman Counts services on the *CMS-1500* claim form. Refer to the *Every Woman Counts* 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.

Billing for Case Management Following Provision of Breast or Cervical Cancer Screening Services

Figure 1: Billing for annual case management.

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

The recipient ID number (which is computer generated after the online *Recipient Information* form is completed and submitted) is entered in the *Insured's ID Number* field (Box 1a).

When submitting a claim for case management, an ICD-9-CM diagnosis code is required in the *Diagnosis or Nature of Illness or Injury* field (Box 21). See "Approved Procedures" in the *Every Woman Counts* section of this manual for a listing of relevant ICD-9-CM diagnosis codes.

Only cycles with findings that require immediate work-up and additional referrals and coordination of services are eligible for claim submission for case management. HCPCS code T1017 is used to bill for this service. This service is payable only to the Primary Care Provider (PCP).

A case management HCPCS code is entered in the *Procedures, Services or Supplies* field, Box 24D. To qualify to bill this case management fee, the recipient's PCP is required to have submitted clinical information using the online breast/cervical cancer screening cycle data forms.

Note: PCPs are reimbursed for case management only when they have completed all required screening and follow-up services and forms within the recipient's active eligibility period. Case management will be paid once per recipient, per provider, per calendar year.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a "1" in the *Days or Units* field (Box 24G) for each claim line.

Providers should enter the billing provider's address and phone number in the *Billing Provider Info and Phone Number* field (Box 33) and an NPI number in NPI field (Box 33a).

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be paid correctly.

<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"/> <input type="checkbox"/> <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"/> <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) 909A000005001									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JANE						3. PATIENT'S BIRTH DATE MM DD YY 06 21 47			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				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME						10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME						11. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
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						17a. _____ 17b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. RESERVED FOR LOCAL USE															
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. V10.3															
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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 13 10		11		T1017		5000		1		NPI	NPI	NPI	NPI	NPI	
2 _____		_____		_____		_____		_____		NPI	NPI	NPI	NPI	NPI	
3 _____		_____		_____		_____		_____		NPI	NPI	NPI	NPI	NPI	
4 _____		_____		_____		_____		_____		NPI	NPI	NPI	NPI	NPI	
5 _____		_____		_____		_____		_____		NPI	NPI	NPI	NPI	NPI	
6 _____		_____		_____		_____		_____		NPI	NPI	NPI	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see b3a0) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 5000		29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ 5000			
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>John Doe</i> SIGNED _____ DATE 09/30/10						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. _____						
NUCC Instruction Manual available at: www.nucc.org															
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)															

Figure 1. Breast and Cervical Cancer Screening Billed With Annual Case Management.