

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

eyeglass fram ex

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## **Eyeglass Frames Example: CMS-1500**

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This example will help providers bill for eyeglass frames on the *CMS-1500* claim form. Refer to the *Eyeglass Frames* section of this manual for policy information. Refer to the *CMS-1500 Completion for Vision Care* section in 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 in this manual.

**Billing Tips:** When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts, or dollar signs with the charges. When entering modifiers, do not include hyphens. 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.

**Frame Replacement**

*Figure 1. Frame replacement.*

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

In this example, an optometrist is billing for the replacement of eyeglass frames. Previous eyeglass frames, which were ordered less than two years ago, are broken beyond repair. The optometrist has obtained a signed statement from the recipient in regards to the circumstances for replacement of the frames to maintain in the medical record.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that service was rendered in an office. Primary ICD-9-CM code 367.4 (Presbyopia) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

Since one replacement frame is required for the recipient, HCPCS code V2020 (frames, purchases) is billed with modifier RA (replacement) in the *Procedures, Services, or Supplies* field (Box 24D) and quantity "1" in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

The long term care facility's name and National Provider Identifier (NPI) are entered in the *Name of Referring Provider or Other Source* (Box 17) and *NPI* (Box 17a) fields to indicate that the recipient meets the Optional Benefits Exclusion exemption. This information is required on the claim for the reimbursement of HCPCS code V2020. Refer to the *Optional Benefits Exclusion* section in this manual for additional information.

Refer to the *Eyeglass Frames* section in this manual for policy and instructions for billing.

<p><b>1500</b></p> <p><b>HEALTH INSURANCE CLAIM FORM</b></p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>																																																																							
<p>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"/></p> <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN</b></p> <p>3. PATIENT'S BIRTH DATE <b>06 21 02</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>9000000A95001</b></p> <p>5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b></p> <p>6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p> <p>7. INSURED'S ADDRESS (No., Street)</p> <p>8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p> <p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE</p> <p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p> <p>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 _____</p> <p>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 _____</p> <p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY</p> <p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY</p> <p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>ABC SKILLED NURSING FACILITY</b></p> <p>17a. NPI 17b. NPI</p> <p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</p> <p>19. RESERVED FOR LOCAL USE</p> <p>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</p> <p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>3670</b> 3. _____ 2. _____ 4. _____</p> <p>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER</p> <p>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. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #</p> <table border="1"> <tr> <td>1</td> <td>06</td> <td>01</td> <td>07</td> <td>11</td> <td>V2020</td> <td>RP</td> <td>5000</td> <td>1</td> <td>NPI</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> </table> <p>25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gmt claims, see 10000) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <b>5000</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>5000</b></p> <p>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 <b>06/30/07</b></p> <p>32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____</p> <p>33. BILLING PROVIDER INFO &amp; PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b> a. <b>0123456789</b> b. _____</p>												1	06	01	07	11	V2020	RP	5000	1	NPI	2									NPI	3									NPI	4									NPI	5									NPI	6									NPI
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<p>NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a> APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>																																																																							

Figure 1. Frame Replacement.