

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

## Family Planning Billing Example: CMS-1500

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The example in this section is to assist providers in billing for HCPCS code A4269 (with appropriate modifier U1–U4) for family planning services on the *CMS-1500* claim form. Refer to the *Family Planning* 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.

**Other Contraceptive Supplies**

*Figure 1. Billing for HCPCS code A4269U1 (contraceptive supply, spermicide [e.g., foam, gel], each)*

*This is a sample only. Adapt to your billing situation accordingly.*

In this example, a woman meets with her physician to discuss family planning and the physician dispenses a contraceptive foam kit and 12 condoms to the recipient. Enter code A4269 (contraceptive supplies) and appropriate modifier U1–U4 in the *Procedures, Services or Supplies* field (Box 24D).

Code A4269 requires documentation of the item(s), quantity and “at cost” expense of the items in the *Reserved for Local Use* field (Box 19) and should be listed as follows:

FOAM KIT @ \$6.00 + 12 CONDOMS @ \$.16 = \$7.92

In the *Date(s) of Service* field (Box 24A), enter the date of the office visit in the six-digit, MMDDYY (Month, Day, Year) format; for example, December 30, 2013 = 123013. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information. Enter Place of Service code 11 (office) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F).

<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>											
<div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> PICA</span> <span>PICA <input type="checkbox"/></span> </div>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <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) <b>9000000A95001</b>					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JANE</b>						3. PATIENT'S BIRTH DATE MM DD YY SEX <b>06 21 82 M <input type="checkbox"/> F <input checked="" type="checkbox"/></b>					
5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY <b>ANYTOWN</b>				STATE <b>CA</b>		7. INSURED'S ADDRESS (No., Street)				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
ZIP CODE <b>95823</b>				TELEPHONE (Include Area Code) <b>(916) 555-5555</b>		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	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				c. EMPLOYER'S NAME OR SCHOOL NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER				12. 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. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		13. INSURED'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.				14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE <b>FOAM KIT @ \$6.00 + 12 CONDOMS @ \$.16 = \$7.92</b>						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. <b>5101</b>						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>12 30 13 11</b>						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
B. PLACE OF SERVICE <b>11</b>						23. PRIOR AUTHORIZATION NUMBER					
C. EMG <b>A4269 U1</b>						24. F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID # <b>7.92</b>					
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) <b>A4269 U1</b>						25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					
E. DIAGNOSIS POINTER <b>U1</b>						26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						28. TOTAL CHARGE \$ <b>7.92</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>7.92</b>					
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.) <b>John Doe</b>						32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b.					
SIGNED <b>John Doe</b> DATE <b>01/7/14</b>						33. BILLING PROVIDER INFO & PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b>					
SIGNED _____ DATE _____						a. <b>0123456789</b> b.					

Figure 1: Billing for HCPCS Code A4269U1 (Contraceptive Supplies).