

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

hear aid ex

1

Hearing Aids: Billing Example

The example in this section is to assist providers in billing for hearing aids on the *CMS-1500* claim form. Refer to the *Hearing Aids* 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 *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Purchase of a Hearing Aid

Figure 1. Purchase of a hearing aid.

This is a sample only. Please adapt to your billing situation. Sample attachments are not illustrated in this example.

In this example, a hearing aid dispenser is billing for a monaural hearing aid. HCPCS code V5050 (hearing aid, monaural, in the ear) is entered in the *Procedures, Services or Supplies* field (Box 24D). Modifier NU is entered to indicate a purchase.

The referring physician's name is entered in the *Name of Referring Provider or Other Source* field (Box 17) and NPI number in Box 17B because a prescription from an otolaryngologist or the attending physician is required.

For information that must be entered in the *Additional Claim Information* field (Box 19), or on an attachment, refer to the *Hearing Aids* section.

In this example, ICD-9-CM code 389.1 (sensorineural hearing loss) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). The usual and customary charges are entered in the *Charges* field (Box 24F).

Because prior authorization is required for the purchase of hearing aids, the *Treatment Authorization Request (TAR)* number is entered in the *Prior Authorization Number* field (Box 23). Refer to the *CMS-1500 Completion* section of this manual for additional information to complete field 23.

The date that the hearing aid was ordered is entered in the *Date(s) of Service* field (Box 24A).

The total charge (Box 28) should include local sales tax. Medi-Cal limits the total cost of hearing aid benefit services, including sales tax, to \$1,510 per recipient per fiscal year (*Welfare and Institutions Code [W&I Code], Section 14131.05*).

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 42 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"/>					
CITY ANYTOWN			STATE CA		8. RESERVED FOR NUCC USE			CITY		
ZIP CODE 985235555		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 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)					
11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
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 QUAL.					15. OTHER DATE MM DD YY QUAL.					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. BOB SMITH					17a. NPI 0123456789					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) SEE ATTACHMENT					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.					22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. 3891 B. _____ C. _____ D. _____					23. PRIOR AUTHORIZATION NUMBER 01234567890					
E. _____ F. _____ G. _____ H. _____					F. \$ CHARGES G. DAYS OR UNITS H. EP/SBT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					
I. _____ J. _____ K. _____ L. _____					1 08 10 14 11 V5050 NU 66500 1 NPI					
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER					2					
3					4					
5					6					
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 66500	
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> SIGNED _____ DATE 8/30/14					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. Purchase of a Hearing Aid.