

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

Medical Transportation – Air: Billing Examples

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Examples in this section are to assist providers in billing for air transportation on the *CMS-1500* claim form. Refer to the *Medical Transportation – Air* 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.

Emergency Air Transport

Figure 1. Emergency Air Transport.

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

In this example, an emergency air transport is being billed. HCPCS codes A0430 (ambulance service, conventional air services, transport, one way [fixed wing]) and A0435 (fixed wing air mileage, per statute mile) are entered in the *Procedures, Services or Supplies* field (Box 24D).

All emergency medical air transportation requires that the *EMG* field (Box 24C) is checked and a statement included in the *Reserved for Local Use* field (Box 19), or on an attachment to the claim, showing that an emergency existed.

In this example, "See attachment for justification of codes A0430 and A0435" has been entered in the *Reserved for Local Use* field (Box 19) to indicate that the documentation is attached to the claim.

- When billing HCPCS code A0430, documentation must include the name of the person/agency that requested service, nature of emergency, name of the hospital the patient was taken to, clinical information on the patient's condition, reason the services were deemed medically necessary, time/date of transport and name of physician responsible for the patient.
- When billing HCPCS code A0435, documentation must include the Global Positioning System (GPS) coordinates of the point of takeoff and point of landing using the degrees, minutes and decimal minutes (DD:MM.MMM) format only. Claims using any other format will be denied.

A maximum of 999 statute miles may be billed on one claim line. For distances greater than this, use multiple claim lines. In this example, the total distance is 2,617 statute miles. This distance has been split onto three separate claim lines of 999, 999 and 619 statute miles.

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

| 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) 90000000A95001 | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN | | | | | 3. PATIENT'S BIRTH DATE MM DD YY 06 21 62 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"/> | | 7. INSURED'S ADDRESS (No., Street) | | |
| CITY ANYTOWN | | STATE CA | | | 8. RESERVED FOR NUCC USE | | CITY | | STATE |
| 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: | | 11. INSURED'S POLICY GROUP OR FECA NUMBER |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" 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. CLAIM CODES (Designated by NUCC) |
| b. RESERVED FOR NUCC USE | | c. RESERVED FOR NUCC USE | | | d. INSURANCE PLAN NAME OR PROGRAM NAME | | 11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | | SEX |
| c. RESERVED FOR NUCC USE | | d. INSURANCE PLAN NAME OR PROGRAM NAME | | | 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. | | 11. OTHER CLAIM ID (Designated by NUCC) |
| SIGNED _____ | | DATE _____ | | | SIGNED _____ | | 11. INSURANCE PLAN NAME OR PROGRAM NAME | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i> |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | | 15. OTHER DATE QUAL. 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 | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY |
| 17a. _____ | | 17b. NPI _____ | | | 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) SEE ATTACHMENT FOR JUSTIFICATION OF CODES A0430 AND A0435 | | 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. |
| A. _____ | | B. _____ | | | C. _____ | | D. _____ | | E. _____ |
| F. _____ | | G. _____ | | | H. _____ | | I. _____ | | J. _____ |
| K. _____ | | L. _____ | | | 22. RESUBMISSION CODE | | 23. PRIOR AUTHORIZATION NUMBER | | 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) CPT/HCPCS MODIFIER | | E. DIAGNOSIS POINTER | | F. \$ CHARGES |
| G. DAYS OR UNITS | | H. EPSDT Family Plan | | | I. ID. QUAL. | | J. RENDERING PROVIDER ID. # | | |
| 1 | | 09 04 14 | | | 42 X A0430 | | 1275 00 | | 1 |
| 2 | | 09 04 14 | | | 42 A0422 | | 9 98 | | 1 |
| 3 | | 09 04 14 | | | 42 A0435 | | 14235 75 | | 999 |
| 4 | | 09 04 14 | | | 42 A0435 | | 14235 75 | | 999 |
| 5 | | 09 04 14 | | | 42 A0435 | | 8820 75 | | 619 |
| 6 | | | | | | | | | NPI |
| 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 \$ 38802.23 |
| 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> | | 32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____ | | 33. BILLING PROVIDER INFO & PH # (916) 555-5555 ABC AIR EMERGENCY 5412 MAYFLOWER AVE ANYTOWN CA 958235555 |
| SIGNED _____ | | DATE 10/01/14 | | | a. 0123456789 | | b. _____ | | |

Figure 1. Emergency Air Transport.