

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

Medical Transportation – Ground: Billing Examples

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

**Non-Emergency
Transport**

Figure 1. Non-Emergency Transport.

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

In this example, a medical transport company is billing for a non-emergency trip from the patient's home to a dialysis clinic and back. HCPCS codes A0130 (non-emergency transportation: wheelchair van) and A0425 (ground mileage, per statute mile) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because HCPCS code A0425 is billed on a per mile basis, the total mileage is entered in the *Days or Units* field (Box 24G). A "2" is entered in the *Days or Units* field (Box 24G) for HCPCS code A0130 to indicate that the transport was round trip, to and from the dialysis clinic.

Also in this example, a referring physician's name is entered in the *Name of Referring Provider or Other Source* field (Box 17) and NPI in Box 17B because a written prescription from the patient's physician is required for the non-emergency transport to and from the dialysis clinic.

Also note that an approved *Treatment Authorization Request* (TAR) is required for non-emergency transportation. The TAR number is entered in the *Prior Authorization Number* field (Box 23).

A description of the trip is shown in the *Reserved for Local Use* field (Box 19) of the claim indicating the times the patient was picked up for each trip. Because mileage is billed, the complete origination and destination addresses, including cities and ZIP codes, are required in the *Reserved for Local Use* field (Box 19) or on an attachment to the claim.

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"/> (Medicare#) MEDICAID <input checked="" type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					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)		ZIP CODE		TELEPHONE (Include Area Code) ()					
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		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)		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>							
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.					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. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
					17b. NPI 0123456789		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) RESPONSE TO CALL/ROUND TRIP TRANS ON THE SAME DAY OF SER. FROM PAT HOME AT 509 OAKS ST., ANYTOWN, CA 95831 TO ANYTOWN DIALYSIS CLINIC 401 JAY ST., ANYTOWN, CA 95831 (10:15) & RETURN TRIP TO PAT. HOME (13:45)														
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. _____ B. _____ C. _____ D. _____					E. _____ F. _____ G. _____ H. _____		23. PRIOR AUTHORIZATION NUMBER 01234567891							
I. _____ J. _____ K. _____ L. _____					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 09 04 14 41 A0130 35 30 2 NPI														
2 09 04 14 41 A0425 15 60 12 NPI														
3														
4														
5														
6														
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. 12345		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 50 90		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 NON-EMERGENCY TRANSPORT 14555 HILLSIDE AVE ANYTOWN CA 958235555					a. 1234567890					b. _____				
SIGNED _____ DATE 10/01/14														

Figure 1. Non-Emergency Transport.

Emergency Transport*Figure 2. Emergency Transport.*

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

In this example, a medical transport company is billing for emergency transportation from the patient's home to an acute care hospital. HCPCS codes A0429 (Ambulance service, basic life support, emergency transport [BLS-emergency]), A0422 (Ambulance [ALS or BLS] oxygen and oxygen supplies, life sustaining situation) and A0380 (BLS mileage [per mile]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because emergency services are being billed, an "X" is entered in the *EMG* field (Box 24C).

All emergency medical transportation requires a statement in the *Reserved for Local Use* field (Box 19) of the claim, or on an attachment, supporting that the emergency existed. The name of the person/agency that requested the service, nature of emergency, name of the hospital the patient was transported to, clinical information on patient's condition, reason the service was considered immediately necessary, and the name of the physician accepting responsibility for the patient is entered in the *Reserved for Local Use* field (Box 19) or on an attachment. When billing a night call charge, code A0427 (Ambulance service, advanced life support, emergency transport, level 1 [ALS1-emergency]) or code A0429, depending on whether the services provided are advanced life support (ALS) or basic life support (BLS), is billed with modifier UJ (services provided at night). The time the service was rendered must be entered in the *Reserved for Local Use* field (Box 19) or on an attachment.

Because mileage is billed, the complete origination and destination addresses, including city and ZIP code, are required in the *Reserved for Local Use* field (Box 19) or on an attachment to the claim.

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 62 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			
ZIP CODE 95823		TELEPHONE (Include Area Code) (916) 555-5555						ZIP CODE			
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			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)			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>			
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, INJURY, or PREGNANCY (LMP) MM DD YY 09 04 2014 QUAL:					15. OTHER DATE MM DD YY QUAL:			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. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
17b. NPI _____					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) EMERG. AMBUL. FROM HOME AT 12:55 AM, 509 OAKS ST., ANYTOWN, CA 95831 TO ANYTOWN HOSP. 401 JAY ST. ANYTOWN, CA 95831. DIAG: SCHIZ DISORDER, ALCOHOL DEPENDENCY, UNRESPONSIVE. PATIENT'S SPOUSE CALLED FOR AMBUL. DR. DENISE SMITH IS M.D. RESPONSIBLE						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)					ICD Ind. _____		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
A. _____ B. _____ C. _____ D. _____					E. _____ F. _____ G. _____ H. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.				
I. _____ J. _____ K. _____ L. _____					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. EPOSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 04 14		41	X	A0429 UJ			128 08	1		NPI	
2 09 04 14		41		A0422			9 98	1		NPI	
3 09 04 14		41		A0380			53 25	15		NPI	
4										NPI	
5										NPI	
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 \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use	
				12345				\$ 191 31			
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 10/01/14				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				33. BILLING PROVIDER INFO & PH # (916) 555-5555 MIDTOWN AMBULANCE 345 ELM ANYTOWN CA 958235555			
				a. 0123456789		b. _____					

Figure 2. Emergency Transport.