

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

Occupational Therapy Billing Example: CMS-1500

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1



The example in this section is to assist providers in billing for occupational therapy services on the *CMS-1500* claim form. Refer to the *Occupational Therapy* 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.

Follow-Up Visit*Figure 1. Follow-up Visit.*

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

In this example, an occupational therapist is billing for a routine therapy visit.

The patient's accident/injury was not employment related; therefore, an "X" is entered in the *No* box of the *Employment* field (Box 10A), and the date that the accident/injury occurred is entered in the *Date of Current* field (Box 14). ICD-9-CM code 726.4 (enthesopathy of wrist and carpus) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

The referring provider's name and National Provider Identifier (NPI) are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a prescription is required for all therapy services.

Also in this example, HCPCS codes X4110 (treatment – initial 30 minutes) and X4112 (treatment – each additional 15 minutes) are entered in the *Procedures, Services or Supplies* field (Box 24D).

An "11" is entered in the *Place of Service* field (Box 24B) indicating that the therapy services were rendered at the therapist's office.

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

<p align="center">1500</p> <p align="center">HEALTH INSURANCE CLAIM FORM</p> <p align="center">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>											
<p align="right">PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>											
<p>1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/></p>						<p>1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90000000A95001</p>					
<p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN</p>						<p>3. PATIENT'S BIRTH DATE MM DD YY SEX 06 21 62 M <input checked="" type="checkbox"/> <input type="checkbox"/></p>					
<p>5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET</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>CITY ANYTOWN</p>				<p>STATE CA</p>		<p>7. INSURED'S ADDRESS (No., Street)</p>				<p>CITY STATE</p>	
<p>ZIP CODE 95823</p>				<p>TELEPHONE (Include Area Code) (916) 555-5555</p>		<p>8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>				<p>ZIP CODE TELEPHONE (Include Area Code) ()</p>	
<p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>						<p>10. IS PATIENT'S CONDITION RELATED TO:</p>					
<p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p>						<p>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>					
<p>b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/></p>						<p>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____</p>					
<p>c. EMPLOYER'S NAME OR SCHOOL NAME</p>						<p>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p>						<p>10d. RESERVED FOR LOCAL USE</p>					
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</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.</p>						<p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p>					
<p>SIGNED _____ DATE _____</p>						<p>a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/></p>					
<p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)</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.</p>					
<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY</p>						<p>SIGNED _____</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</p>					
<p>17a. _____</p>						<p>17b. NPI 0123456789</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)</p>					
<p>1. 726 4</p>						<p>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</p>					
<p>2. _____</p>						<p>23. PRIOR AUTHORIZATION NUMBER</p>					
<p>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</p>						<p>B. PLACE OF SERVICE</p>					
<p>C. EMG</p>						<p>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</p>					
<p>E. DIAGNOSIS POINTER</p>						<p>F. \$ CHARGES</p>					
<p>G. DAYS OR UNITS</p>						<p>H. EP301 Family Plan</p>					
<p>I. ID. QUAL.</p>						<p>J. RENDERING PROVIDER ID. #</p>					
<p>1 10 17 07 11 X4110 35 50 1 NPI</p>						<p>25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/></p>					
<p>2 10 17 07 11 X4110 11 00 1 NPI</p>						<p>26. PATIENT'S ACCOUNT NO.</p>					
<p>3 _____</p>						<p>27. ACCEPT ASSIGNMENT? (If or gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>					
<p>4 _____</p>						<p>28. TOTAL CHARGE \$ 46 50</p>					
<p>5 _____</p>						<p>29. AMOUNT PAID \$</p>					
<p>6 _____</p>						<p>30. BALANCE DUE \$ 46 50</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.)</p>						<p>32. SERVICE FACILITY LOCATION INFORMATION</p>					
<p>SIGNED <i>Jane Doe</i> DATE 10/30/07</p>						<p>33. BILLING PROVIDER INFO & PH # (916) 555-5555</p>					
<p>a. NPI</p>						<p>JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555</p>					
<p>b. _____</p>						<p>a. 1234567890 b. _____</p>					
<p>NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>											

Figure 1. Follow-Up Visit.