

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

## Physical Therapy Billing Example: CMS-1500

---

phys exc  
1



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

## Physical Therapy Visits

### *Figure 1. Physical Therapy Visits.*

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

In this example, a physical therapist is billing for an initial evaluation and subsequent therapy visits. HCPCS codes X3920 (any of the tests and measurements – initial 30 minute, plus report) and X3908 (treatment, including a combination of any modalities and procedures) are entered in the *Procedures, Services or Supplies* field (Box 24D).

Since the patient's accident/injury is not employment related, an "X" is entered in the *No* box of the *Employment* field (Box 10A). The date that the accident/injury occurred is entered in the *Date of Current* field (Box 14).

All physical therapy services require prior authorization. The *Treatment Authorization Request (TAR)* number is entered in the *Prior Authorization Number* field (Box 23). Also, physical therapists are reimbursed for services only if the services are in response to the written prescription of licensed practitioners, acting within the scope of their practice. The referring physician'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 the physical therapist is billing for an initial evaluation, a statement saying this must be entered in the *Reserved for Local Use* field (Box 19).

In this example, ICD-9-CM code 726.10 (Achilles bursitis or tendinitis) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Enter the usual and customary charges in the *Charges* field (Box 24F).

<p><b>1500</b></p> <p><b>HEALTH INSURANCE CLAIM FORM</b></p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</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>2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN</b></p>						<p>3. PATIENT'S BIRTH DATE MM   DD   YY <b>06   21   62</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/></p>			<p>1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>90000000A95001</b></p>		
<p>5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b></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>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</p>		
<p>CITY <b>ANYTOWN</b></p>			<p>STATE <b>CA</b></p>			<p>8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>7. INSURED'S ADDRESS (No., Street)</p>		
<p>ZIP CODE <b>95823</b></p>			<p>TELEPHONE (Include Area Code) <b>(916) 555-5555</b></p>			<p>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></p>			<p>CITY</p>		
<p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>			<p>10. IS PATIENT'S CONDITION RELATED TO:</p>			<p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p>			<p>STATE</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>a. INSURED'S DATE OF BIRTH MM   DD   YY M <input type="checkbox"/> F <input type="checkbox"/></p>			<p>ZIP CODE</p>		
<p>b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY 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>b. EMPLOYER'S NAME OR SCHOOL NAME</p>			<p>TELEPHONE (Include Area Code) ( )</p>		
<p>c. EMPLOYER'S NAME OR SCHOOL NAME</p>			<p>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>			<p>c. INSURANCE PLAN NAME OR PROGRAM NAME</p>			<p>10d. RESERVED FOR LOCAL USE</p>		
<p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p>			<p>10d. RESERVED FOR LOCAL USE</p>			<p>d. 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></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>SIGNED _____ DATE _____</p>						<p>SIGNED _____</p>					
<p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM   DD   YY <b>09   20   07</b></p>				<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY</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 <b>DR. BOB SMITH</b></p>				<p>17a. _____ 17b. NPI <b>0123456789</b></p>				<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY</p>			
<p>19. RESERVED FOR LOCAL USE <b>INITIAL EVALUATION</b></p>				<p>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES</p>				<p>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</p>			
<p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>726 10</b></p>				<p>23. PRIOR AUTHORIZATION NUMBER <b>01234567890</b></p>				<p>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. EP301 Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #</p>			
<p>1 <b>10   06   07</b> <b>11</b> <b>X3920</b> <b>50.00</b> <b>1</b> NPI</p>				<p>2 <b>10   06   07</b> <b>11</b> <b>X3908</b> <b>40.00</b> <b>1</b> NPI</p>				<p>3 <b>10   06   07</b> <b>11</b> <b>X3908</b> <b>40.00</b> <b>1</b> NPI</p>			
<p>4 <b>10   06   07</b> <b>11</b> <b>X3908</b> <b>40.00</b> <b>1</b> NPI</p>				<p>5 _____ _____ _____ _____ _____ NPI</p>				<p>6 _____ _____ _____ _____ _____ NPI</p>			
<p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p>				<p>26. PATIENT'S ACCOUNT NO.</p>				<p>27. ACCEPT ASSIGNMENT? (If or gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
<p>28. TOTAL CHARGE \$ <b>170.00</b></p>				<p>29. AMOUNT PAID \$</p>				<p>30. BALANCE DUE \$ <b>170.00</b></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.) <i>Jane Doe</i></p>				<p>32. SERVICE FACILITY LOCATION INFORMATION</p>				<p>33. BILLING PROVIDER INFO &amp; PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b></p>			
<p>SIGNED _____ DATE <b>10/30/07</b></p>				<p>a. <b>NPI</b> b. _____</p>				<p>a. <b>1234567890</b> b. _____</p>			
<p>NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a> APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>											

Figure 1. Physical Therapy Visits.