

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

Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – CMS-1500

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Examples in this section are to help providers bill for Comprehensive Perinatal Services Program (CPSP) services on the *CMS-1500* claim form. Refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* 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.

Combined Assessments and Initial Office Visit Within Four Weeks

Figure 1: Combined assessments and initial pregnancy-related office visit billed within four weeks.

HCPCS code Z1032 (initial comprehensive pregnancy-related office visit) with ZL modifier (indicating the office visit occurred within 16 weeks of the Last Menstrual Period) and code Z6500 (combined assessments) are entered in the *Procedures, Services or Supplies* field (Box 24D). HCPCS code 6500 is reimbursable only when a recipient receives all three initial nutritional, health education and psychosocial assessments and the initial pregnancy-related office visit within four weeks of entry into care.

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code V22.0 represents supervision of a normal first pregnancy.

In the *Date(s) of Service* field (Box 24A), the date of the office visit, June 7, 2007 is entered on claim line 1 as 060707. (This is the recipient's entry-into-care date.) The date of service entered on claim line 2 for HCPCS code Z6500 is June 20, 2007 (062007), which is the date of the last assessment. Enter Place of Service code 11 (office) in Box 24B.

Certification that all three assessments were rendered and the dates they were provided are entered in the *Reserved for Local Use* field (Box 19). In this example, all three services were provided on the same date of service.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both codes Z1032 and Z6500.

19. RESERVED FOR LOCAL USE NUTRITION, HEALTH EDUCATION AND PSYCHOSOCIAL ASSESSMENTS PROVIDED										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V220										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.							
2. _____										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From To MM DD YY 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	06	07	07			11		Z1032	ZL			18294	1		NPI				
2	06	20	07			11		Z6500				13583	1		NPI				
3															NPI				
4															NPI				

Figure 1. Combined Assessments and Initial Pregnancy-Related Office Visit Billed Within Four Weeks.

**Antepartum Nutrition,
Psychosocial and Health
Assessment Services**

Figure 2: Billing follow-up antepartum nutritional counseling, psychosocial support and health education services.

Breast-Feeding

Follow-up antepartum nutritional counseling, psychosocial and health education codes are reimbursable for a variety of pre-delivery counseling services, including breast-feeding.

HCPCS code Z6204 (follow-up antepartum nutrition assessment), code Z6304 (follow-up antepartum psychosocial assessment) and Z6406 (follow-up antepartum health education assessment) are entered in the *Procedures, Services or Supplies* field (Box 24D). These services are reimbursed on an itemized basis only and must not be billed globally.

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code V23.0 represents a pregnancy with a history of infertility.

In the *Date(s) of Service* field (Box 24A), the date the nutrition assessment (Z6204) service was rendered, June 8, 2007, is entered on claim line 1 as 060807. The dates of service for codes Z6304 and Z6406 are respectively entered as 060807 and 070407. Enter Place of Service code 11 (office) for each claim line in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Units for these codes are billed in 15-minute increments. (Refer to “Calculating Billing Units” in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* section of this manual for instructions to bill services rendered for more or less than 15 minutes.) Entering a 2 in the *Days or Units* field (Box 24G) for both codes Z6204 and Z6304 indicates that the provider spent at least 23 minutes each performing the psychosocial and nutrition assessments. Entering a 1 for code Z6406 indicates the provider spent at least 8 minutes performing the health education assessment.

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

19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE				ORIGINAL REF. NO.															
1. V230										23. PRIOR AUTHORIZATION NUMBER																			
2. _____																													
3. _____																													
4. _____																													
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From MM DD YY To MM DD YY										SERVICE		EMG		CPT/HCPCS MODIFIER				DIAGNOSIS POINTER		\$ CHARGES		DAYS OF UNITS		EPSDT Family Plan		ID. QUAL.		RENDERING PROVIDER ID. #	
1										06 08 07		11		Z6204						1682		2				NPI			
2										06 08 07		11		Z6304						1682		2				NPI			
3										07 14 07		11		Z6406						841		1				NPI			
4																										NPI			

Figure 2. Billing CPSP for Nutritional Counseling, Psychosocial Support and Health Education Services. (May be Used to Bill for Counseling Services Related to Breast-Feeding.)

Early and Frequent Prenatal Care

Figure 3: Early entry into care (modifier ZL).

The Department of Health Care Services (DHCS) established modifier ZL exclusively for use by CPSP providers. Modifier ZL, billed with the initial comprehensive pregnancy-related office visit (Z1032), adds \$56.63 to the maximum reimbursement for the initial office visit.

Enter the date of the Last Menstrual Period in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14).

Enter HCPCS code Z1032 with modifier ZL (indicating the office visit occurred within 16 weeks of the Last Menstrual Period) in the *Procedures, Services or Supplies* field (Box 24D).

Enter an appropriate ICD-9-CM diagnosis code in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code V22.0 represents supervision of a normal first pregnancy.

In the *Date(s) of Service* field (Box 24A), enter the date of the office visit, November 7, 2007 on claim line 1 as 110707. Enter Place of Service code "11" (office) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for code Z1032.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 09 15 07		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE 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 17a: _____ 17b: NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V220		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE 11	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) Z1032 ZL	E. DIAGNOSIS POINTER
F. \$ CHARGES 18294		G. DAYS OR UNITS 1	H. EPSDT (Firm) PBO	I. ID QUAL	J. RENDERING PROVIDER ID. # NPI
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (If 26 gmt. submit, use 99999) <input type="checkbox"/> YES <input type="checkbox"/> NO
28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	

Figure 3. Initial Comprehensive Pregnancy-Related Office Visit With ZL Modifier Certifying that the Patient was Seen Within 16 Weeks of Her Last Menstrual Period.

Tenth Antepartum Office Visit

Figure 4: Tenth antepartum office visit.

HCPCS code Z1036 is used solely by CPSP providers to bill the 10th antepartum office visit.

CPSP providers who choose to bill globally for the nine previously rendered visits and who are claiming reimbursement for the 10th antepartum visit must document the dates of the initial pregnancy-related visit and the subsequent eight antepartum visits in the *Reserved for Local Use* field (Box 19).

Enter HCPCS code Z1036 in the *Procedures, Services or Supplies* field (Box 24D).

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code 640.9 represents unspecified hemorrhage in early pregnancy.

In the *Date(s) of Service* field (Box 24A), enter the office visit date, June 29, 2007, on claim line 1 as 062907. Enter Place of Service code "11" (office) in Box 24B.

Code Z1036 is reimbursable for \$113.26. Enter the amount, without decimal points, in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for code Z1036.

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

19. RESERVED FOR LOCAL USE 122206, 011207, 021207, 032207, 041607, 052007, 053007, 061607										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 6409										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.							
2. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE										F. \$ CHARGES		G. DAYS OR UNITS		H. EPOSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS POINTER								
1	06	29	07			11		Z1036				11326	1			NPI			
2															NPI				
3															NPI				
4															NPI				

Figure 4. Tenth Antepartum Office Visit. Payable Once Per Patient Per Pregnancy Regardless of the Number of Visits Made in Addition to the 10th Visit.

TAR and Claim for Reimbursement of Excess Services

Figures 5 and 6: TAR and claim for reimbursement of excess services.

Providers may submit a *Treatment Authorization Request* (TAR) for approval of nutrition, psychosocial and/or health education services in excess of the maximums listed in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) List of Billing Codes* section of this manual.

The TAR and claim on the following pages illustrate how the TAR and claim were completed for Jane Doe, who required additional nutritional services due to diabetes.

Refer to the *TAR Completion* section of this manual for instructions to complete the TAR.

For the claim, enter HCPCS code Z6204 (follow-up antepartum nutrition assessment) in the *Procedures, Services or Supplies* field (Box 24D) on separate claim lines due to the different dates of service.

In the *Date(s) of Service* field (Box 24A), the first date of service, December 10, 2007, is entered on the claim line 1 as 121007 and the second date of service, December 17, 2007, is entered on claim line 2 as 121707. Enter Place of Service code 11 (office) in Box 24B.

Enter the date of the Last Menstrual Period in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14).

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code 648.0 represents diabetes mellitus.

In this case, 30 minutes of follow-up nutrition services were rendered on December 10, 2007 and 30 minutes were rendered on December 17, 2007. A unit equals 15 minutes so a 2 is entered in the *Days or Units* field (Box 24G) for each claim line. (Refer to "Calculating Billing Units" in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) List of Billing Codes* section of this manual for instructions to bill services rendered for more or less than 15 minutes.)

Code Z6204 is reimbursable at \$8.41 for each unit so \$16.82 (2 x \$8.41) is entered in the *Charges* field (Box 24F). The charges for both services are added together (\$33.64) and entered in the *Total Charge* field (Box 28).

Note: The entire 11-digit TAR control number (in this case, 01234567890) is entered in the *Prior Authorization Number* field (Box 23).

STATE
USE
ONLY

5

TYPewriter ALIGNMENT
Elite Pica

CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY

CCN

F.I. USE ONLY

40	41
42	43

TYPewriter ALIGNMENT
Elite Pica

TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE

VERBAL CONTROL NO. _____

TYPE OF SERVICE REQUESTED: DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDICARE ELIGIBLE? YES NO

PROVIDER PHONE NO. (916) 555-5555

3. PROVIDER NUMBER: 0123456789

PROVIDER NAME AND ADDRESS:
• MARY BROWN
• 1456 MAIN STREET
• ANYTOWN CA 958235555

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED DENIED DEFERRED

2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) JACKSON VS RANK PARAGRAPH CODE

BY: Sue Smith

MEDI-CAL CONSULTANT REVIEW COMMENTS INDICATOR

I.D. # DATE

34 35 44

COMMENTS/EXPLANATION

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.): DOE, JANE

MEDI-CAL IDENTIFICATION NO. 90000000A95001

SEX: F AGE: 35 DATE OF BIRTH: 052172

STREET ADDRESS: 1234 MAIN STREET

CITY, STATE, ZIP CODE: ANYTOWN CA 98523

PHONE NUMBER: (916) 555-5555

PATIENT STATUS: HOME BOARD & CARE

DIAGNOSIS DESCRIPTION: DIABETES MELLITUS IN PREGNANCY ICD-9-CM DIAGNOSIS CODE: 6480

MEDICAL JUSTIFICATION:
35-YEAR-OLD GRAV IV, PARA III, EDC 10-2-07 WITH HISTORY OF GESTATIONAL DIABETES. HAS MAINTAINED MARGINAL LEVELS OF ACCEPTABLE BLOOD SUGAR THROUGHOUT PREGNANCY. NEEDS ONE HOUR VISITS WEEKLY OF NUTRITIONAL FOLLOW-UP FOR REMAINDER OF PREGNANCY TO ASSURE ADEQUATE DIET, CONTROLLED BLOOD. ADDITIONAL SERVICES WILL PROVIDE NECESSARY SUPPORT SO PREGNANCY OUTCOME IS OPTIMIZED.

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36

LINE NO.	AUTHORIZED Y/M	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	<input checked="" type="checkbox"/> Y	<input type="text" value="32"/>	FOLLOW-UP ANTEPARTUM NUTRITIONAL INTERVENTION	<input type="text" value="32"/>	<input type="text" value="Z6204"/>	<input type="text" value="32"/>	\$ <input type="text" value="26912"/>
2	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
3	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
4	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
5	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
6	<input type="checkbox"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

Mary Brown MD 100607

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

37 FROM DATE: 38 TO DATE:

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

TAR CONTROL NUMBER

39 OFFICE: SEQUENCE NUMBER: P1:

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY 50-1 03/07

Figure 5. Correctly Filled Out TAR for Additional CPSP Services. Corresponds to the Claim on the Next Page.

<p>1500</p> <p>HEALTH INSURANCE CLAIM FORM</p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p> <p>PICA <input type="checkbox"/> PICA <input type="checkbox"/></p>																	
<p>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"/></p> <p>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</p>						<p>1a. INSURED'S I.D. NUMBER (For Program in Item 1)</p> <p>9000000A95001</p>											
<p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p>DOE JANE</p>						<p>3. PATIENT'S BIRTH DATE</p> <p>MM DD YY 05 21 72 M <input type="checkbox"/> F <input checked="" type="checkbox"/></p>			<p>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</p>								
<p>5. PATIENT'S ADDRESS (No., Street)</p> <p>1234 MAIN STREET</p>						<p>6. PATIENT RELATIONSHIP TO INSURED</p> <p>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>7. INSURED'S ADDRESS (No., Street)</p>								
<p>CITY</p> <p>ANYTOWN</p>				<p>STATE</p> <p>CA</p>		<p>8. PATIENT STATUS</p> <p>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>CITY</p>			<p>STATE</p>					
<p>ZIP CODE</p> <p>95823</p>			<p>TELEPHONE (Include Area Code)</p> <p>(916) 555-5555</p>			<p>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/></p>			<p>ZIP CODE</p>			<p>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>11. INSURED'S POLICY GROUP OR FECA NUMBER</p>					
<p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p>						<p>a. EMPLOYMENT? (Current or Previous)</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>						<p>a. INSURED'S DATE OF BIRTH</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>					
<p>b. OTHER INSURED'S DATE OF BIRTH</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>						<p>b. AUTO ACCIDENT? PLACE (State)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>						<p>b. EMPLOYER'S NAME OR SCHOOL NAME</p>					
<p>c. EMPLOYER'S NAME OR SCHOOL NAME</p>						<p>c. OTHER ACCIDENT?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>						<p>c. INSURANCE PLAN NAME OR PROGRAM NAME</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?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></p>					
<p>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>SIGNED _____ DATE _____</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>SIGNED _____</p>											
<p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)</p> <p>MM DD YY</p>			<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</p> <p>MM DD YY</p>			<p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p> <p>FROM MM DD YY TO MM DD YY</p>											
<p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p>						<p>17a. _____</p>			<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES.</p> <p>FROM MM DD YY TO MM DD YY</p>								
<p>17b. NPI _____</p>						<p>20. OUTSIDE LAB? \$ CHARGES</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>											
<p>19. RESERVED FOR LOCAL USE</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)</p> <p>1. 648 0 3. _____</p> <p>2. _____ 4. _____</p>						<p>23. PRIOR AUTHORIZATION NUMBER</p> <p>01234567891</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) MODIFIER</p>		<p>E. DIAGNOSIS POINTER</p>	<p>F. \$ CHARGES</p>	<p>G. DAYS OR UNITS</p>	<p>H. EFSBT Family Plan</p>	<p>I. ID QUAL</p>	<p>J. RENDERING PROVIDER ID. #</p>						
<p>1 12 10 07 11 Z6204 16:82 2 NPI</p>																	
<p>2 12 10 07 11 Z6204 16:82 2 NPI</p>																	
<p>3 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p>																	
<p>4 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p>																	
<p>5 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p>																	
<p>6 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p>																	
<p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p>			<p>26. PATIENT'S ACCOUNT NO.</p>			<p>27. ACCEPT ASSIGNMENT? (For gov. claims, see b330) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>28. TOTAL CHARGE \$ 33:64</p>		<p>29. AMOUNT PAID \$</p>		<p>30. BALANCE DUE \$ 33:64</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><i>Mary Brown</i></p> <p>SIGNED _____ DATE 12/30/07</p>						<p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI _____ b. _____</p>			<p>33. BILLING PROVIDER INFO & PH # (916) 555-5555</p> <p>JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555</p> <p>a. 0123456789 b. _____</p>								
<p>NUCC Instruction Manual available at: www.nucc.org</p>																	
<p>APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>																	

Figure 6. Complete CMS-1500 Claim Form. Corresponds to TAR on Preceding Page.