

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

pro serv ex

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## Professional Services Examples: CMS-1500

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Examples in this section will help providers bill for professional services on the *CMS-1500* claim form. Refer to the *Professional Services* section of this manual for policy information. Refer to the *CMS-1500 Completion for Vision Care* 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, dollar amounts or dollar signs with the charges. If requested information does not fit neatly in the *Reserved for Local Use* (Box 19) of the *CMS-1500* claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**Interim Comprehensive  
Eye Examination**

*Figure 1. Interim comprehensive eye examination.*

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

In this example, an optometrist is billing for a comprehensive eye examination for a recipient that last received services within the 24-month benefit period.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that services were rendered in an office. ICD-9-CM code 250.5 (diabetes with ophthalmic manifestations) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

**Note:** A valid ICD-9-CM diagnosis code is required when billing for a comprehensive eye examination within the 24-month benefit period.

CPT-4 code 92014 (ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, one or more visits) is billed on line 1 of the *Procedures, Services, or Supplies* field (Box 24D) for the comprehensive eye examination. Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

If the refraction test was performed, enter CPT-4 code 92015 (determination of refractive state) in the *Procedures, Services, or Supplies* field (Box 24D). Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete remaining fields on the claim. Refer to the *Professional Services* section in this manual for policy information.

Refer to the *Professional Services: Diagnosis Codes* section in this manual for a list of required ICD-9-CM codes when billing for an additional comprehensive eye examination within the 24-month benefit period.

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> <b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>													
<small>PICA</small> <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"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>90000000A95001</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN</b>						3. PATIENT'S BIRTH DATE MM DD YY SEX <b>06 21 62 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>							
4. INSURED'S NAME (Last Name, First Name, Middle Initial)						5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b>							
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)							
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
11. INSURED'S POLICY GROUP OR FECA NUMBER				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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY <b>06 01 07</b>						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. _____ 17b. NPI _____							
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						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) 1. <b>250 5</b> 3. _____							
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 EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS H. EPST Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1		06 01 07		11		92014		100 00		1 NPI			
2		06 01 07		11		92015		30 00		1 NPI			
3										NPI			
4										NPI			
5										NPI			
6										NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see b340) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>130 00</b>		29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>130 00</b>	
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. <b>NPI</b> b. _____							
SIGNED <i>Jane Doe</i> DATE <b>06/30/07</b>						33. BILLING PROVIDER INFO & PH # <b>(916) 555-5555</b> <b>JANE SMITH</b> <b>1027 MAIN STREET</b> <b>ANYTOWN CA 958235555</b> a. <b>0123456789</b> b. _____							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1. Interim Comprehensive Eye Examination.

**Out-of-Office Call**

*Figure 2. Out-of-office call.*

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

In this example, an optometrist is providing a comprehensive eye examination for a recipient in an inpatient hospital. Because the patient was seen in an inpatient hospital, the optometrist is billing CPT-4 code 99056 (services provided at request of patient in a location other than the physician's office, which are normally provided in the office) in addition to the comprehensive eye exam (CPT-4 code 92004).

Enter "21" in the *Place of Service* field (Box 24B) to indicate that services were rendered in an inpatient hospital. In this example, ICD-9-CM code 368.9 (unspecified visual disturbance) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

CPT-4 code 92004 (ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits) is billed on line 1 of the *Procedures, Services, or Supplies* field (Box 24D) for the comprehensive eye examination. Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

Since the services were performed at an inpatient hospital, enter CPT-4 code 99056 in the *Procedures, Services, or Supplies* field (Box 24D). Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

The optometrist has written, "Justification attached to claim" in the *Reserved for Local Use* field (Box 19), indicating the required justification letter for an out-of-office call is attached to the claim.

Refer to the *CMS-1500 Completion for Vision Care* section of this manual for instructions to complete remaining fields on the claim. Refer to the *Professional Services* section in this manual for policy information.

<div style="border: 1px solid black; border-radius: 5px; padding: 2px; display: inline-block;">1500</div> <h2 style="margin: 0;">HEALTH INSURANCE CLAIM FORM</h2> <p style="font-size: small; margin: 0;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>																																																																				
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PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></td> </tr> <tr> <td colspan="3">7. INSURED'S ADDRESS (No., Street)</td> </tr> <tr> <td colspan="2">CITY <b>ANYTOWN</b></td> <td>STATE <b>CA</b></td> </tr> <tr> <td colspan="2">ZIP CODE <b>95823</b></td> <td>TELEPHONE (Include Area Code) <b>(916) 555-5555</b></td> </tr> <tr> <td colspan="3">8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></td> </tr> <tr> <td colspan="3">9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td> </tr> <tr> <td colspan="3">10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE</td> </tr> <tr> <td colspan="3">11. INSURED'S POLICY GROUP OR FECA NUMBER</td> </tr> <tr> <td colspan="3">a. INSURED'S DATE OF BIRTH (MM   DD   YY) SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/></td> </tr> <tr> <td colspan="3">b. EMPLOYER'S NAME OR SCHOOL NAME</td> </tr> <tr> <td colspan="3">c. INSURANCE PLAN NAME OR PROGRAM NAME</td> </tr> <tr> <td colspan="3">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></td> </tr> <tr> <td colspan="3">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 _____</td> </tr> <tr> <td colspan="3">13. 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<p>NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a> <span style="float: right;">APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</span></p>																																																																				

Figure 2. Out-of-Office Call.

## Visual Field Examination

*Figure 3. Visual Field Examination.*

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

In this example, an optometrist is billing for a visual field examination.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that services were rendered in an office. ICD-9-CM code 365.10 (open-angle glaucoma) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

**Note:** A valid ICD-9-CM code is required when billing for a visual field examination.

CPT-4 code 92083 (visual field examination, unilateral or bilateral, with interpretation and report; extended examination) is billed on line 1 of the *Procedures, Services, or Supplies* field (Box 24D) for the visual field examination. Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete remaining fields on the claim. Refer to the *Professional Services* section in this manual for policy information.

Refer to the *Professional Services: Diagnosis Codes* section in this manual for a list of required ICD-9-CM codes when billing for a visual field examination.

<div style="text-align: right;">1500</div> <h2 style="text-align: center;">HEALTH INSURANCE CLAIM FORM</h2> <p style="text-align: center;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>																																																																																																																																																																																																																																																																																																																																																																														
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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3. Visual Field Examination.