

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

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Radiology Billing Examples: CMS-1500

The examples in this section are to help providers bill radiology procedures on the *CMS-1500* claim form. Refer to the *Radiology: Diagnostic* 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 *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Chest X-ray

Figure 1. Chest X-ray.

This is an example only. Please adapt to your billing situation.

In this example, CPT-4 code 71020 (radiologic examination, chest; two views, frontal and lateral) is billed without a modifier (indicating both professional and technical components were provided) in the *Procedures, Services or Supplies* field (Box 24D).

In the *Date(s) of Service* field (Box 24A), the date of the office visit, August 8, 2015 is entered on claim line 1 as 080815. Enter Place of Service code 11 (office) in Box 24B.

Enter the referring provider name in the *Name of Referring Provider or Other Source* field (Box 17) and the referring provider's NPI in Box 17B. Enter the rendering provider's information in *Service Facility Location Information* field (Box 32) and the NPI in Box 32A.

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 71020.

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 958235555		TELEPHONE (Include Area Code) (916) 555-5555				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 If yes, complete items 9, 9a, and 9d.				
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			15. OTHER DATE QUAL. 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 DR. BOB SMITH			17a. NPI 0123456789			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												
22. 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	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSTD Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 08 15		11		71020				27.00	1		NPI	
2											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 govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 27.00	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> SIGNED _____ DATE 08/30/15			32. SERVICE FACILITY LOCATION INFORMATION JOHN SMITH 9876 FIRST STREET ANYTOWN CA 958235555 a. 1234567890 b.				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.					
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)												

Figure 1. Chest X-ray.

Bilateral Radiography Billed with Unilateral Codes

Figure 2. Bilateral radiography billed with unilateral code.

This is an example only. Please adapt to your billing situation.

In this case a physician orders a bilateral eye socket X-ray. This claim example illustrates the billing of a bilateral radiographic procedure with a unilateral code.

In the *Additional Claim Information* field (Box 19), enter a statement declaring a bilateral procedure was done but was billed with a unilateral code.

In this example, CPT-4 code 70190 (radiologic examination; optic foramina) is billed with modifier TC (technical component) in the *Procedures, Services or Supplies* field (Box 24D).

In the *Date(s) of Service* field (Box 24A), the date of the office visit, August, 2015 is entered on claim line 1 as 080815. Enter Place of Service code 11 (office) in Box 24B.

Enter the referring provider name in the *Name of Referring Provider or Other Source* field (Box 17) and the referring provider's NPI in Box 17B. Enter the rendering provider's information in *Service Facility Location Information* field (Box 32) and the NPI in Box 32A.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 2 in the *Days or Units* field (Box 24G) for code 70190. This number indicates the procedure is bilateral. Enter in the *Additional Claim Information* field (Box 19) that the procedure was performed bilaterally.

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)				3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
DOE, JOHN				06 21 62		M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)					
1234 MAIN STREET				Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>							
CITY		STATE		8. RESERVED FOR NUCC USE				CITY		STATE	
ANYTOWN		CA									
ZIP CODE		TELEPHONE (Include Area Code)						ZIP CODE		TELEPHONE (Include Area Code)	
958235555		(916) 555-5555									
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)				a. INSURED'S DATE OF BIRTH			
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?				b. OTHER CLAIM ID (Designated by NUCC)			
				<input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)							
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME			
				<input type="checkbox"/> YES <input type="checkbox"/> NO							
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 If yes, complete items 9, 9a, and 9d.			
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 _____						DATE _____					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
MM DD YY QUAL.				MM DD YY QUAL.				FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
DR. BOB SMITH				0123456789		0123456789		FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
EYE SOCKET X-RAY, PROCEDURE DONE BILATERALLY											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.											
A. _____ B. _____ C. _____ D. _____											
E. _____ F. _____ G. _____ H. _____											
I. _____ J. _____ K. _____ L. _____											
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	
From MM DD YY To MM DD YY		MM DD YY				CPT/HCPCS MODIFIER				G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
08 08 15		11				71090 TC				27.00 2 NPI	
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID	
SSN EIN <input type="checkbox"/> <input type="checkbox"/>						<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 54.00		\$ 54.00	
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # (916) 555-5555			
SIGNED Jane Doe				JOHN SMITH 9876 FIRST STREET ANYTOWN CA 958235555				JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555			
DATE 08/30/15				a. 1234567890		b.		a. 0123456789		b.	

Figure 2. Bilateral Radiography Billed with Unilateral Code.