
Medical Supplies: Billing Examples

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The examples in this section are to assist providers in billing for medical supplies on the *CMS-1500* claim form. Refer to the *Medical Supplies* section of this manual for detailed policy information. For incontinence supplies, refer to the *Incontinence Medical Supplies* sections of this manual for more 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 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.

Note: Only incontinence medical supplies require ICD-10-CM diagnosis code(s) on the claim.

Tracheostomy Supplies: Contracted

Figure 1. Tracheostomy supplies, contracted.

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

In this example, a Durable Medical Equipment (DME) company is billing for contracted tracheostomy supplies. Medical supply codes A4605 (tracheal suction catheter, closed system, each), A4623 (tracheostomy, inner cannula), A4624 (tracheal suction catheter, any type other than closed system, each) and A7520 (tracheostomy/laryngectomy tube, noncuffed, polyvinylchloride [PVC], silicone or equal, each) are entered in the *Procedures, Services or Supplies* field (Box 24D).

Because the supplies are being delivered to the patient's home, "12" is entered in the *Place of Service* field (Box 24B).

Claims for contracted medical supplies require a product qualifier/UPN in the shaded area of Box 24A. The unit of measure and numeric quantity in the shaded area of Box 24D are optional. Absence of these two elements will not result in claim denial. These numbers are based on the product dispensed to the recipient. See the *List of Contracted Tracheostomy Supplies* spreadsheet for a listing of UPNs and UPN qualifiers. Also see the *CMS-1500 Completion* section for more details about both the qualifier/UPN and the unit of measure/quantity.

Note: This example illustrates billing for contracted medical supplies. An attachment (invoice, manufacturer's catalog page or price list) is not required when billing for contracted medical supplies.

Claims for non-contracted medical supplies with a listed price do not require a qualifier/UPN or an attachment (invoice, manufacturer's catalog page or price list). However, non-contracted supplies without a listed price do require documentation of product cost as an attachment (invoice, manufacturer's catalog page or price list) to the claim.

Enter the usual and customary charges in the *Charges* field (Box 24F). For additional help in calculating charges, providers may refer to upper billing limit information in the *Medical Supplies* section.

Enter the number of units for each medical supply item being billed in the *Days or Units* field (Box 24G).

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

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 BLX/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		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				b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE				c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)				c. INSURANCE PLAN NAME OR PROGRAM NAME					
c. RESERVED FOR NUCC USE				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 <i>If yes, complete items 9, 9a, and 9d.</i>				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
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						17a. _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
17b. NPI						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 EMG		C. _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. SPST/ Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 UK30609038045178		12		UN0000002000						2300		2						NPI			
2 UK35019315052655		12		UN0000002000						500		2						NPI			
3 UK10190752103177		12		UN0000006000						1100		6						NPI			
4 UK35021312009877		12		UN0000001000						10000		1						NPI			
5																		NPI			
6																		NPI			
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 13900		29. AMOUNT PAID		30. Rev'd 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.) SIGNED <i>Jane Doe</i> DATE 10/01/18						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555									
a. NPI						b. 0123456789															

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Figure 1: Tracheostomy Supplies: Contracted.

Attachment Invoice Requirements

Figure 2. Attachment Invoice Requirements.

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

In this example, the provider is using an invoice as the attachment for reimbursement of medical supplies. For the claim to be processed, the invoice attachment must contain all of the required elements listed below. The information does not need to be in this order.

Manufacturer/Distributor – The name and address of the manufacturer or distributor from whom the medical supplies were purchased (in this case Fix It Medical at 1569 Main Street).

Bill to – The name and address of the company being billed for the medical supplies.

Ship to – The ship-to address or business Drug Enforcement Agency (DEA) number is not required on medical supply invoices.

Invoice number – The number assigned to the purchase of the supplies from the supplier.

Invoice date – The date of the invoice. This date must be prior to the date of service. The date of the invoice cannot be more than one year prior to the date of service.

Quantity – The total quantity received by the provider.

Item/UPN Number – Manufacturer's or distributor's product number or UPN number of the item purchased.

Shipping Units – The unit of measurement that the product is packaged in when received by the provider, such as box, case or each. For the reimbursement process, the shipping unit information will be broken down for each. Providers may hand write the units breakdown on the invoice for clarification purposes. (Example: Case = 1 box of 30 each).

Description – The description of the product purchased by the provider.

Unit Price – The price of the unit size purchased by the provider. This price will be broken down to the each price for reimbursement. (Example: 1 case = \$4.68 (after discount) divided by 30 in each box = \$0.1560 each).

Discounts – Amount of discount, if any, must be reported and applied to the purchase price.

Total amount – The total amount for the number of shipped units purchased by the provider including any discounts given to the provider.

Certification Statement – Providers must self-certify that the cost of items on invoices claimed do not contain any hidden or added charges, fees or cost to invoices, discounts or other price reductions not billable to Medi-Cal.

Additional Invoice Requirements

Invoices must not be altered.

Any explanatory information added to the invoice by the provider to assist in the reimbursement process may only be handwritten. Typewritten information (other than a certification statement), attached labels or covered information will result in the claim being denied.

Providers are required to include the certification statement below exactly as written on all invoices and on each invoice page. The item claimed must be clearly identified on the invoice if the item number is not identified on the statement.

“I certify that I have properly disclosed and appropriately reflected a discount or other reduction in price obtained from a manufacturer or wholesaler in the costs claimed or charges on this invoice identified by item number _____ as stated in 42 U.S.C. 1320a-7b (b) (3) (A) of the Social Security Act and this charge does not exceed the upper billing limit as established in California Code of Regulations (CCR) Title 22, Section 51008.1 (a) (2) (D).”

Note: The certification statement may be typed, printed, or stamped onto the invoice, or otherwise attached to the claim.

FIX IT MEDICAL COMPANY							
1569 Main Street Mytown, CA 90000 Phone: 555-555-5555 Fax: 555-555-5556							
Bill To	Johnson's Medical Supply 690 West 14 th Avenue Johnsonville, CA 98721 555-555-5021	Ship To	The ship-to address or Drug Enforcement Agency (DEA) number are not required on medical supply invoices.	Invoice # 11005			
				Invoice Date: February 13, 2009			
				Customer ID: JMS189			
DATE	YOUR ORDER #	OUR ORDER #	SALES REP.	F.O.B.	SHIP VIA	TERMS	TAX ID
2/13/09	567890		Susie		Fed Ex	1% net 30	
QTY	ITEM/UPN #	SHIPPING UNITS	DESCRIPTION	UNIT PRICE	DISCOUNT %	TOTAL	
1	410	CS	410 Catheter (1 Bx. Per CS.- 30 Ea. Bx.)	\$5.20	10%	\$4.68	
						Subtotal	\$4.68
						Tax	\$0.36
						Shipping	\$1.00
						Miscellaneous	
Please return the portion below with your payment.						BALANCE DUE	\$6.04
REMITTANCE							
Invoice #	11005						
Customer ID	JMS189						
Date							
Amount Enclosed							
	Fix It Medical Company 1569 Main Street Mytown, CA 90000	PHONE (555) 555-5555 FAX (555) 555-5556 WEB SITE www.fixit.com					

Figure 2: Attachment Invoice Requirements

Catalog or Price List Requirements

The following are requirements that a catalog or price list must meet to be an acceptable attachment for reimbursement of medical supply claims. Invoice requirements are listed on a previous page in this section.

Medical supply claims requiring a manufacturer catalog or price list attachment for reimbursement must meet the following requirements:

- Catalog or price lists must not be dated more than five years, prior to the date of service.
- The type of catalog or price list must be included in the title of the document. Acceptable types of catalogs or price lists include Manufacturer's Wholesale, Dealer and Distributor.
- Pricing columns found on the catalog or price list page must include one or more of the following types of pricing:
 - Average Wholesale Price (AWP) *
 - Suggested Wholesale Price (SWP)
 - Suggested Wholesale Resale (SWR)
 - Unit Price
 - Net Price
 - Quantity Discount
 - Contracted Price
 - Case Price
- Catalog and price lists must include the package quantities.
- A copy of the front cover of the catalog or price list must accompany the page(s) submitted with a claim from each source catalog or price list when the individual page(s) does not contain an identification of the type of catalog and a date.

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Catalogs or price lists that contain <u>only</u> an AWP pricing column will not be accepted.