California Children's Services (CCS) Program Billing Example: CMS-1500

Page updated: September 2020

The example in this section assists providers in California Children's Services (CCS) program billing on the *CMS-1500* claim form. The explanations on the following page emphasize billing issues common to all CCS providers – proper use of Service Authorization Request (SAR) numbers, NPI numbers and client ID numbers. Refer to *the CMS-1500 Completion* section in 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.

Refer to the *California Children's Services (CCS) Program* section in this manual for policy information.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts, or dollar signs with the charges. 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.

Important Fields for CCS Claim Completion

Figure 1. Completing fields for CCS claims: Service Authorization Request (SAR), NPI and client ID numbers.

This is a sample only. Please adapt to your billing situation. Attachments are not illustrated in this example.

In this example, a physician is billing for surgical procedures rendered at an inpatient hospital. Two CPT® codes are billed with modifiers in the *Procedures, Services or Supplies* field (Box 24D).

Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind*. area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Insured's ID Number

Enter the client's identification number in the *Insured's ID Number* field (Box 1A) as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

Note: For providers billing without a SAR number with prefix "91" or "97" for CCS-only or CCS/Healthy Families clients, leave this field blank.

Authorization Request

Enter the 11-digit SAR number in the *Prior Authorization Number* field (Box 23).

Note: For providers billing without a SAR number with prefix "91" or "97", leave this field blank.

Referring Provider

Enter a referring physician's NPI in Box 17B. If the service was rendered pursuant to a referring physician's SAR, then the SAR number from the referring physician must be included on the claim form. If the services provided were not pursuant to a referring physician's SAR, then leave the *Name of Referring Provider or Other Source* field (Box 17) blank.

Rendering Provider

If the provider is billing with a group NPI, enter the NPI number of the provider who rendered the service in the *Rendering Provider ID Number* field (Box 24J).

Facility Where Services Were Rendered

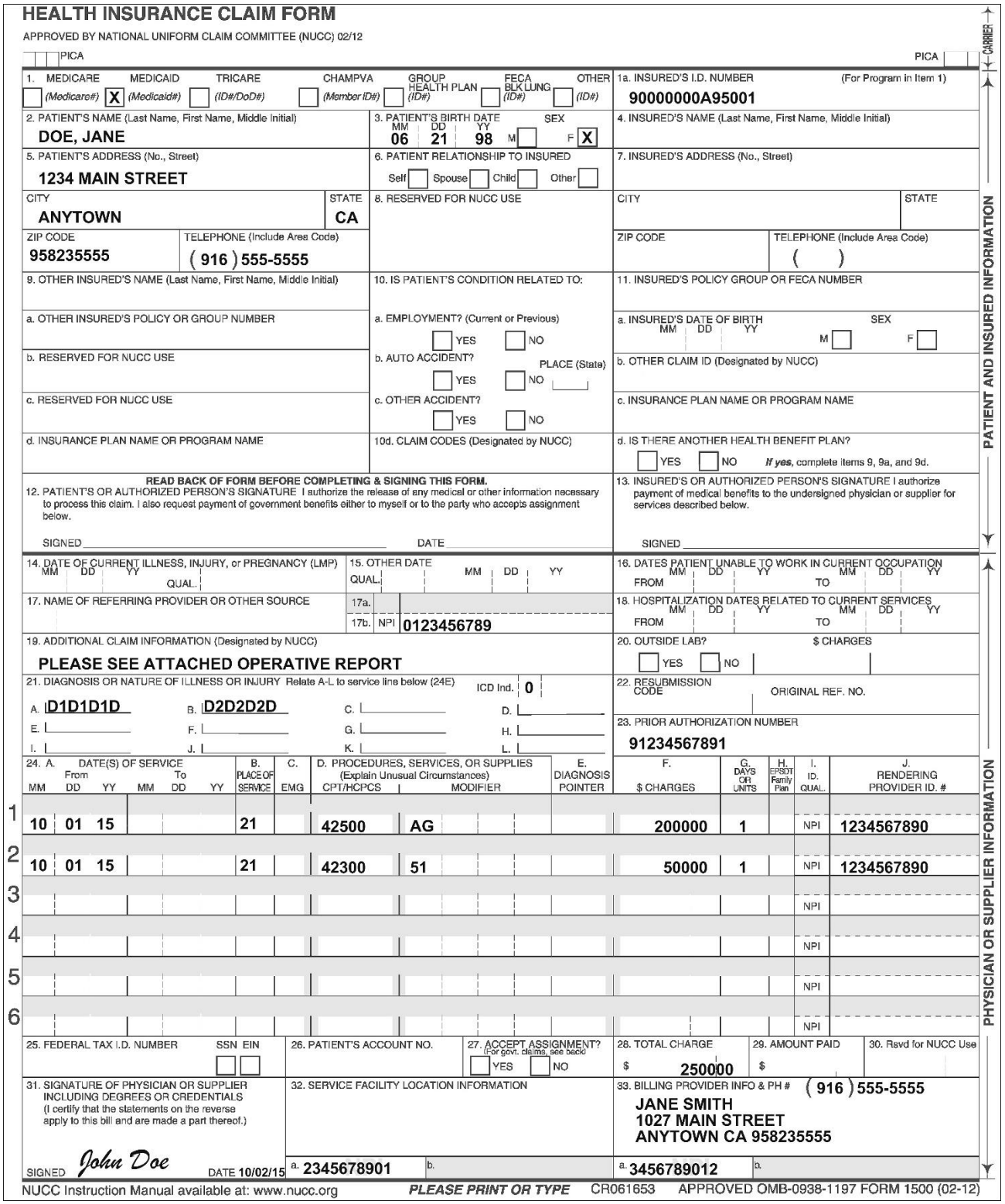
Because the service is being rendered in an inpatient setting, *the Service Facility Location Information* field (Box 32) must contain the facility information. Enter the NPI in Box 32A.

Billing Provider Information

Enter the billing provider's address and phone number in the *Billing Provider Info and Phone Number* field (Box 33) and an NPI number in Box 33A.

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

Figure 1: Completing Fields for CCS Claims: SAR, NPI and Client ID Numbers.



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 98 SEX M F X

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 Spouse Child Other

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)

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

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PLEASE SEE ATTACHED OPERATIVE REPORT

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 91234567891

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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	15			21		42500	AG		200000	1		NPI	1234567890
2	10	01	15			21		42300	51		50000	1		NPI	1234567890
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 250000

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.)

SIGNED John Doe DATE 10/02/15

32. SERVICE FACILITY LOCATION INFORMATION

a. 2345678901 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 3456789012 b.

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‹‹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.