
Family Planning Billing Example: CMS-1500

Page updated: September 2020

The example in this section is to assist providers in billing for HCPCS code A4269 (with appropriate modifier U1–U4) for family planning services on the *CMS-1500* claim form. Refer to the *Family Planning* 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-10-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.

Other Contraceptive Supplies

Figure 1. Billing for HCPCS code A4269U1 (contraceptive supply, spermicide [e.g., foam, gel], each)

This is a sample only. Adapt to your billing situation accordingly.

In this example, a woman meets with her physician to discuss family planning and the physician dispenses a contraceptive foam kit and 12 condoms to the recipient. Enter code A4269 (contraceptive supply, spermicide) and appropriate modifier U1–U4 in the *Procedures, Services or Supplies* field (Box 24D). Enter code A4267 for male condoms.

Code A4269 requires documentation of the item(s), quantity and “at cost” expense of the items in the *Additional Claim Information* field (Box 19) and should be listed as follows:

FOAM KIT @ \$6.00

In the *Date(s) of Service* field (Box 24A), enter the date of the office visit in the six-digit format.

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.

Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information. Enter *Place of Service* code 11 (office) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F).

HEALTH INSURANCE CLAIM FORM															
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12															
<input type="checkbox"/> PICA										<input type="checkbox"/> 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 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, JANE				3. PATIENT'S BIRTH DATE MM DD YY 06 21 82 M <input type="checkbox"/> F <input checked="" 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: 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 a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				b. RESERVED FOR NUCC USE				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>							
c. RESERVED FOR NUCC USE				d. INSURANCE PLAN NAME OR PROGRAM NAME				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 _____							
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 _____															
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 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							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) FOAM KIT @ \$6.00 12 CONDOMS @ \$.16 = \$1.92															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____															
22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				23. PRIOR AUTHORIZATION NUMBER _____				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
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 OF UNITS	H. P-SBT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 15		11		A4269		U1		600		1	NPI	NPI	NPI	NPI	
2 10 01 15		11		A4267		_____		192		1	NPI	NPI	NPI	NPI	
3 _____		_____		_____		_____		_____		_____	NPI	NPI	NPI	NPI	
4 _____		_____		_____		_____		_____		_____	NPI	NPI	NPI	NPI	
5 _____		_____		_____		_____		_____		_____	NPI	NPI	NPI	NPI	
6 _____		_____		_____		_____		_____		_____	NPI	NPI	NPI	NPI	
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO. _____				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 792		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 <i>John Doe</i> DATE 10/30/15				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b. _____							

Figure 1: Billing for HCPCS Code A4269U1 (Contraceptive Supplies).

<<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.