Medical Transportation – Ground: Billing Examples

Page updated: February 2025

Examples in this section are to assist providers in billing for ground medical transportation on the *CMS-1500* claim form. Refer to the *Medical Transportation – Ground* 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 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-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.

Non-Emergency Transport

Figure 1. Non-Emergency Transport.

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

In this example, a medical transport company is billing for a non-emergency trip from the patient's home to a dialysis clinic and back. HCPCS codes A0130 (non-emergency transportation: wheelchair van) and A0380 (BLS mileage [per mile] [use for wheelchair and litter van transports only]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because HCPCS code A0380 is billed on a per mile basis, the total mileage is entered in the *Days or Units* field (Box 24G). A "2" is entered in the *Days or Units* field (Box 24G) for HCPCS code A0130 to indicate that the transport was round trip, to and from the dialysis clinic.

Also in this example, a referring physician's name is entered in the *Name of Referring Provider or Other Source* field (Box 17) and NPI in Box 17B because a written prescription from the patient's physician is required for the non-emergency transport to and from the dialysis clinic.

Also note that an approved *Treatment Authorization Request* (TAR) is required for non-emergency transportation. The TAR number is entered in the *Prior Authorization Number* field (Box 23).

A description of the trip is shown in the *Additional Claim Information* field (Box 19) of the claim indicating the times the patient was picked up for each trip. Because mileage is billed, the complete origination and destination addresses, including cities and ZIP codes, are required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim. ‹‹The originating and destination addresses, including ZIP codes, should also be added to the *Service Facility Location Information* field (Box 32).›› Modifier “76” (repeat procedure or service by same physician or other qualified health care professional) may be appended to each billing code. Without this information, subsequent trips for the same recipient on the same DOS may be denied as duplicate service.

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

PICA — PICA — CARRIER

1. MEDICARE (Medicare#) / MEDICAID [X] (Medicaid#) / 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, JOHN	3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 — SEX M [X] F [ ]	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)	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) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 _____

PATIENT AND INSURED INFORMATION

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 — MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. BOB SMITH	17a. [ ] 17b. NPI 0123456789	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): RESPONSE TO CALL/ROUND TRIP TRANS ON THE SAME DAY OF SER. FROM PAT HOME AT 509 OAKS ST., ANYTOWN, CA 95831 TO ANYTOWN DIALYSIS CLINIC 401 JAY ST., ANYTOWN, CA 95831 (10:15) & RETURN TRIP TO PAT. HOME		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
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.		22. RESUBMISSION CODE — ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: 0123456789

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 01 01 22		41		A0130	76		40 60	2		NPI	
2 01 01 22		41		A0380			18 00	12		NPI	
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.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE: $ 58 60 — 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 DATE	32. SERVICE FACILITY LOCATION INFORMATION FROM: PATIENT'S HOME 509 OAKS ST. ANYTOWN CA 95831 TO: ANYTOWN DIALYSIS CLINIC 401 JAY ST a. ANYTOWN CA 95831 b.	33. BILLING PROVIDER INFO & PH # (916) 555-5555 NON-EMERGENCY TRANSPORT 14555 HILLSIDE AVE ANYTOWN CA 958235555 a. 1234567890 b.	

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Figure 1. **Non-Emergency Transport.**

Emergency Transport

Figure 2. Emergency Transport.

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

In this example, a medical transport company is billing for emergency transportation from the patient's home to an acute care hospital. HCPCS codes A0429 (Ambulance service, basic life support, emergency transport [BLS-emergency]), A0422 (Ambulance [ALS or BLS] oxygen and oxygen supplies, life sustaining situation) and A0425 (ground mileage, per statute mile [use for ambulance transports only]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because emergency services are being billed, an "X" is entered in the *EMG* field (Box 24C).

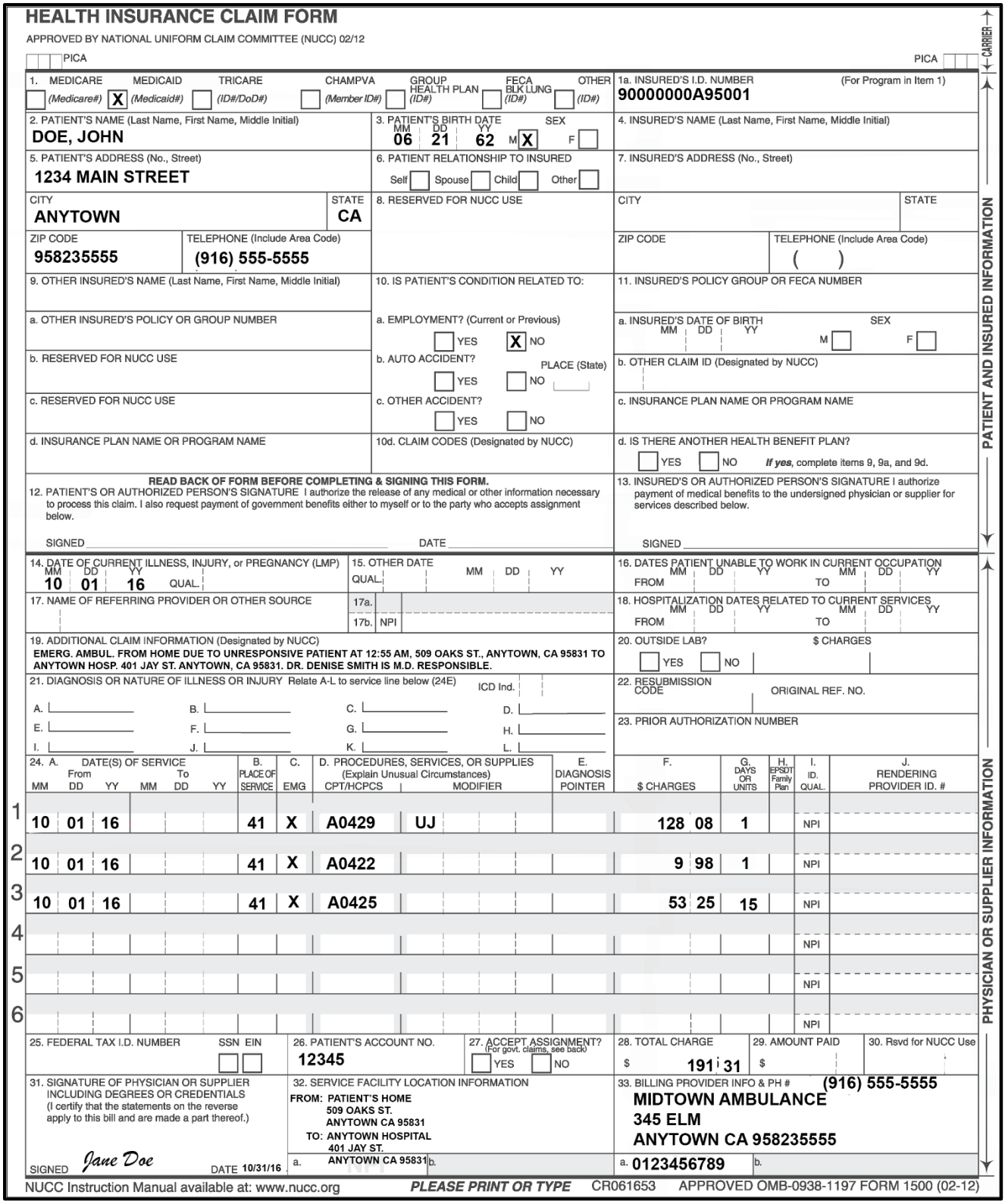
All emergency medical transportation requires both:

- The emergency service indicator on the claim (*EMG* field [Box 24C] on the *CMS-1500* claim form, or condition code 81 [emergency indicator] in boxes 18 thru 24 on the *UB-04* claim form).
- A statement in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form, or *Remarks* field (Box 80) on the *UB-04* claim form, or on an attachment, supporting that an emergency existed. The statement may be made by the provider of transportation and must include:
  - The nature of the emergency
  - The name of the hospital to which a recipient was transported
  - No acronym in place of a hospital name (for example, VMC). Abbreviations are acceptable (for example, Valley Med. Ctr.)
  - The name of the physician (Doctor of Medicine [M.D.] or Doctor of Osteopathic Medicine [D.O.]) accepting responsibility for the recipient. The name of the staff M.D., D.O. or emergency department medical director is acceptable.

Note: A physician's signature is not required

When billing a night call charge, code A0427 (Ambulance service, advanced life support, emergency transport, level 1 [ALS1-emergency]) or code A0429, depending on whether the services provided are advanced life support (ALS) or basic life support (BLS), is billed with modifier UJ (services provided at night). The time the service was rendered must be entered in the *Additional Claim Information* field (Box 19) or on an attachment.

Because mileage is billed, the complete origination and destination addresses, including city and ZIP code, are required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim. ‹‹The originating and destination addresses, including ZIP codes, should also be added to the *Service Facility Location Information* field (Box 32).››



HEALTH INSURANCE CLAIM FORM

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

PICA — PICA — CARRIER

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) 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, JOHN	3. PATIENT'S BIRTH DATE MM 06 DD 21 YY 62 SEX M [X] F [ ]	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)	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) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 10 DD 01 YY 16 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	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) EMERG. AMBUL. FROM HOME DUE TO UNRESPONSIVE PATIENT AT 12:55 AM, 509 OAKS ST., ANYTOWN, CA 95831 TO ANYTOWN HOSP. 401 JAY ST. ANYTOWN, CA 95831. DR. DENISE SMITH IS M.D. RESPONSIBLE.		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
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.		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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 16	41	X	A0429	UJ		128 08	1		NPI	
2 10 01 16	41	X	A0422			9 98	1		NPI	
3 10 01 16	41	X	A0425			53 25	15		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) YES [ ] NO [ ]	28. TOTAL CHARGE $ 191 31	29. AMOUNT PAID $	30. Rsvd for NUCC Use
	12345				

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 DATE 10/31/16	FROM: PATIENT'S HOME 509 OAKS ST. ANYTOWN CA 95831 TO: ANYTOWN HOSPITAL 401 JAY ST. a. ANYTOWN CA 95831 b. NPI	MIDTOWN AMBULANCE 345 ELM ANYTOWN CA 958235555 a. 0123456789 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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***Figure 2*. Emergency Transport.**

Non-Medical Transportation

Figure 3. Non-Medical Transportation.

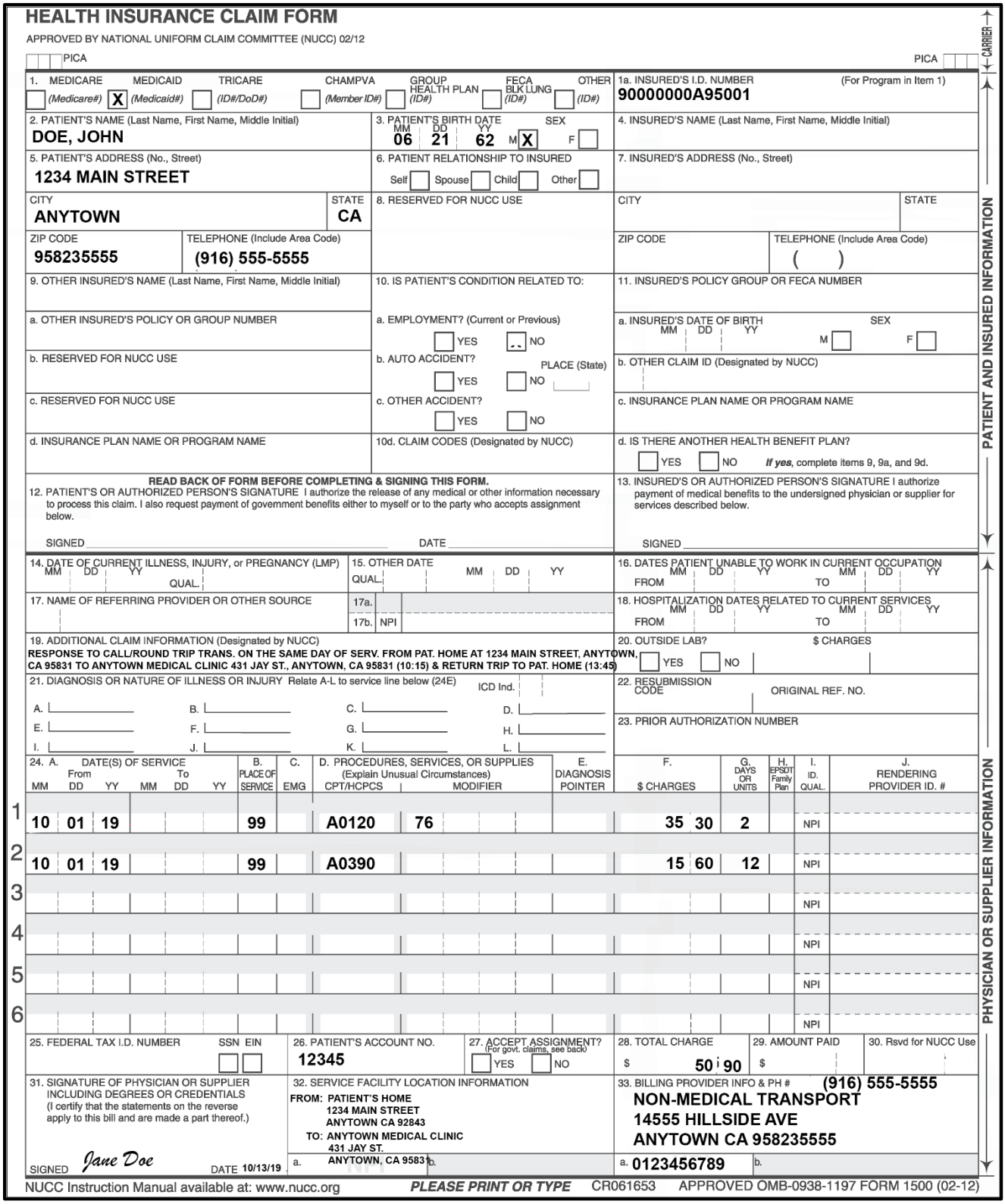
This is a sample only. Please adapt to your billing situation.

In this example, a medical transport company is billing for a trip from the patient's home to a medical clinic and back. Note this patient does not require non-emergency medical transportation by ambulance, wheelchair or litter van. HCPCS codes A0120 (non-emergency transportation: mini-bus, mountain area transports, or other transportation systems) and A0390 (ALS mileage [per mile]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because HCPCS code A0390 is billed on a per mile basis, the total mileage is entered in the *Days or Units* field (Box 24G). A "2" is entered in the *Days or Units* field (Box 24G) for HCPCS code A0120 to indicate that the transport was round trip, to and from the medical clinic.

A description of the trip is shown in the *Additional Claim Information* field (Box 19) of the claim indicating the times the patient was picked up for each trip. Because mileage is billed, the complete origination and destination addresses, including cities and ZIP codes, are required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim. ‹‹The originating and destination addresses, including ZIP codes, should also be added to the *Service Facility Location Information* field (Box 32).››

If multiple trips are provided for the same recipient on the same date of service, enter the time of day and the points of destination in the *Additional Claim Information* field (Box 19) of the *CMS-1500 claims*. Modifier "76" (repeat procedure or service by same physician or other qualified health care professional) may be appended to each billing code on the claims accordingly. Without this information, subsequent trips for the same recipient on the same DOS may be denied as duplicate service.

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

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | 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, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F [ ]

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)

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) YES [ ] NO [ ]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 _____

PATIENT AND INSURED INFORMATION

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
RESPONSE TO CALL/ROUND TRIP TRANS. ON THE SAME DAY OF SERV. FROM PAT. HOME AT 1234 MAIN STREET, ANYTOWN, CA 95831 TO ANYTOWN MEDICAL CLINIC 431 JAY ST., ANYTOWN, CA 95831 (10:15) & RETURN TRIP TO PAT. HOME (13:45)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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.

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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 19			99		A0120	76			35 30	2		NPI	
2	10 01 19			99		A0390				15 60	12		NPI	
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.: 12345

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

28. TOTAL CHARGE $ 50 90

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 Jane Doe DATE 10/13/19

32. SERVICE FACILITY LOCATION INFORMATION
FROM: PATIENT'S HOME
1234 MAIN STREET
ANYTOWN CA 92843
TO: ANYTOWN MEDICAL CLINIC
431 JAY ST.
a. ANYTOWN, CA 95831 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
NON-MEDICAL TRANSPORT
14555 HILLSIDE AVE
ANYTOWN CA 958235555
a. 0123456789 b.

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Figure 3. **Non-Medical Transport.**

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.