Share of Cost (SOC): CMS-1500

Page updated: August 2020

This section explains how to complete claims for services rendered to recipients who paid a Share of Cost (SOC). The procedure codes used in the following examples are for illustration purposes only and may not be reimbursable to all provider types. Refer to the *Share of Cost* (SOC) section in the Part 1 manual for an explanation of SOC and how to determine the following:

- If a recipient must pay an SOC
- The SOC amount a recipient must pay
- If the recipient's SOC is certified for the month

SOC Fields on Claim

SOC amounts are entered in the *Claim Codes* (Box 10D) and *Amount Paid* (Box 29) fields of the *CMS-1500* claim form. Do not enter decimal points or dollar signs. Enter full dollar and cents amounts, even if the amount is even. In the example below, $4.00 is entered as 400. Use only one claim line for each service billed.

Figure 1 is a sample only. Please adapt to your billing situation.

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): **400**

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 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)

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	09	23	14			11		Procedure code/modifier			1500	1		NPI	
2														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.

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

28. TOTAL CHARGE $ 1500

29. AMOUNT PAID $ 400

30. Rsvd for NUCC Use

Figure 1: Sample. Share of Cost Amount in *Claim Codes* Field and *Amount Paid* Field.

Billing Multiple Services Rendered on Different Dates of Service

Case scenario: A recipient with an abscess on her finger goes to the doctor's office. The doctor examines the finger and sends her home with some initial treatment instructions. The abscess does not clear up and she returns to the doctor, who makes an appointment to drain the abscess the following day.

‹‹Case Scenario Table Showing Three Dates of Service and the Amount of Share of Cost Cleared for Each Date of Service››

Dates	Service	Amount	SOC Cleared	Balance
09/22/14	Office visit	$16.00	$16.00	$0.00
09/29/14	Office visit	$10.00	$10.00	$0.00
09/30/14	Drainage	$15.00	$4.00	$11.00
Total	N/A	$41.00	$30.00	$11.00

The recipient pays her entire $30 SOC and the provider performs SOC clearance transactions for each of the services through the eligibility verification system. The recipient's SOC, therefore, is certified and she is eligible for Medi-Cal.

The provider submits a bill to Medi-Cal. Cost of the services rendered totals $41. The first two services are not billed to Medi-Cal because the entire charge is paid as SOC by the recipient. The provider bills Medi-Cal for the $15 service because the Share of Cost covered only $4 of that charge.

To bill, enter the $15 service fee in the *Total Charge* field (Box 28). Enter the amount of the patient's Share of Cost already applied toward the service fee ($4) in the *Claim Codes* (Box 10D) and *Amount Paid* (Box 29) fields.

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

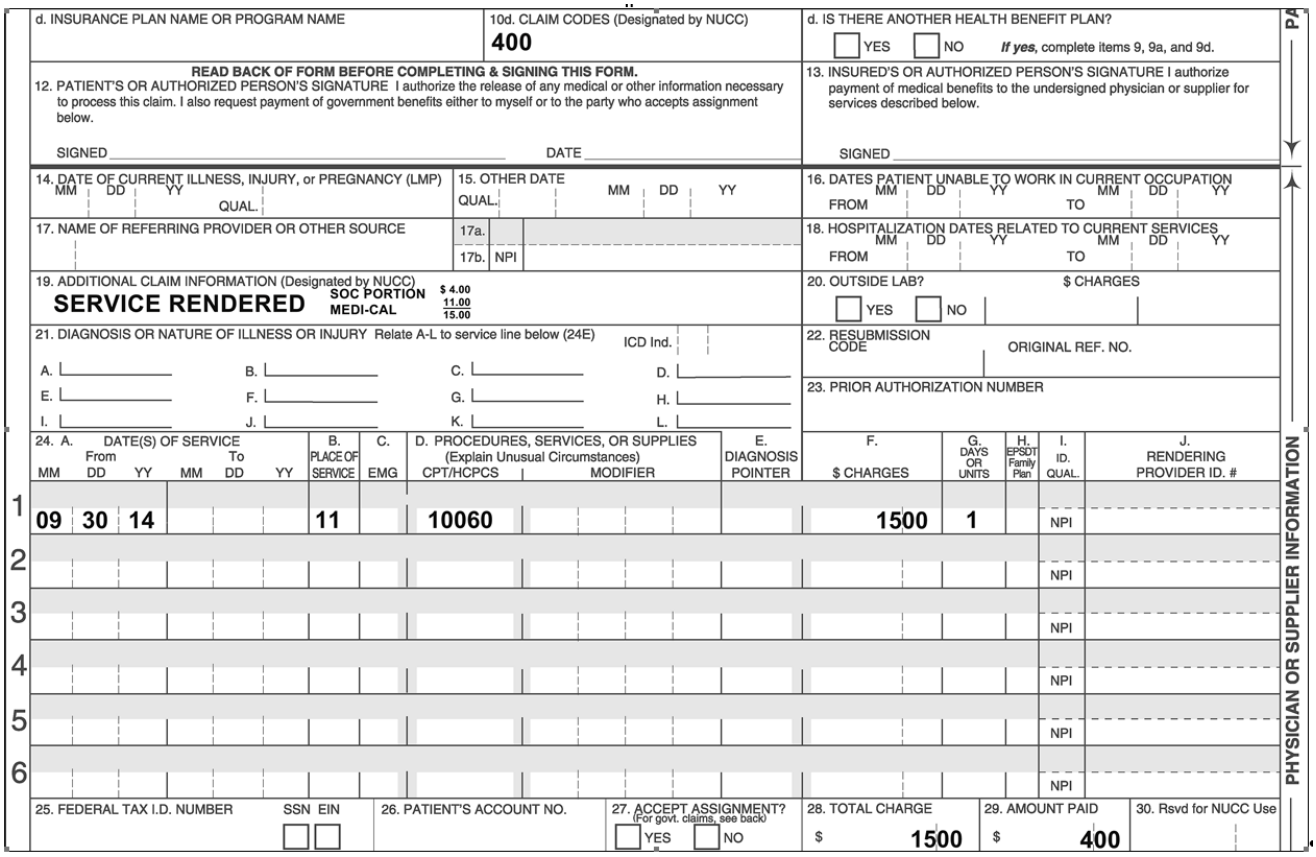

Figure 2: Sample. Multiple Services Rendered on Different Dates of Service.

Box 19: Record Keeping

For record keeping purposes only and to help reconcile payment on the *Remittance Advice Details* (RAD), providers may show in the *Additional Claim* Information field (Box 19) the SOC amount that the recipient paid or obligated.

Billing Multiple Services Rendered on the Same Date of Service

Case scenario: A recipient requires speech therapy services and he receives two speech therapy services on the same day.

‹‹Case Scenario Table Showing Two Office Visits on the Same Date and the Share of Cost Cleared for Each Service››

Dates	Service	Amount	SOC Cleared	Balance
09/23/14	Speech therapy	$75.00	$75.00	$0.00
09/23/14	Speech therapy	$50.00	$10.00	$0.00
Total	N/A	$125.00	$85.00	$40.00

The recipient pays his entire $85 SOC and the provider performs SOC clearance transactions for each of the services through the eligibility verification system. The recipient's SOC, therefore, is certified and he is eligible for Medi-Cal.

The provider submits a bill to Medi-Cal. Cost of the services rendered totals $125. Because both services are rendered on the same day, it is necessary to bill Medi-Cal, as appropriate, for each service. Use two claim lines to bill the two services.

To bill, enter the $125 service fee in the *Total Charge* field (Box 28). Enter the amount of the patient's Share of Cost already applied toward the service charge ($85) in the *Claim Code* (Box 10D) and *Amount Paid* (Box 29) fields.

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

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): **8500**

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 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

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 1: SPEECH EVALUATION
LINE 2: INDIVIDUAL SPEECH THERAPY

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	09	23	14				11		X4301			7500	1		NPI	
2	09	23	14				11		X4303			5000	1		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) ☐ YES ☐ NO

28. TOTAL CHARGE $ 12500

29. AMOUNT PAID $ 8500

30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3: Sample. Multiple Services Rendered on the Same Date of Service.

RAD Payment Summary

Share of Cost claims are reviewed prior to payment. Since the recipient's SOC is applied by the State to pay the $75 service, this service appears as "Denied" on the *Remittance Advice Details* (RAD code 022) or appears with a payment amount of $0.00. The $50 service appears in the "Approved" group as partially paid. The Medi-Cal allowed amount for this service is reduced by the remaining SOC amount. RAD code 408 indicates payment was reduced because of recipient liability.

‹‹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.