Durable Medical Equipment (DME): Billing Examples

Page updated: September 2020

Examples in this section are to assist providers in billing for durable medical equipment on the CMS-1500 claim. Refer to the *Durable Medical Equipment (DME): An Overview* section of this manual for 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 by 11-inch sheet of paper and attach it to the claim.

Listed DME

Figure 1. Listed DME.

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

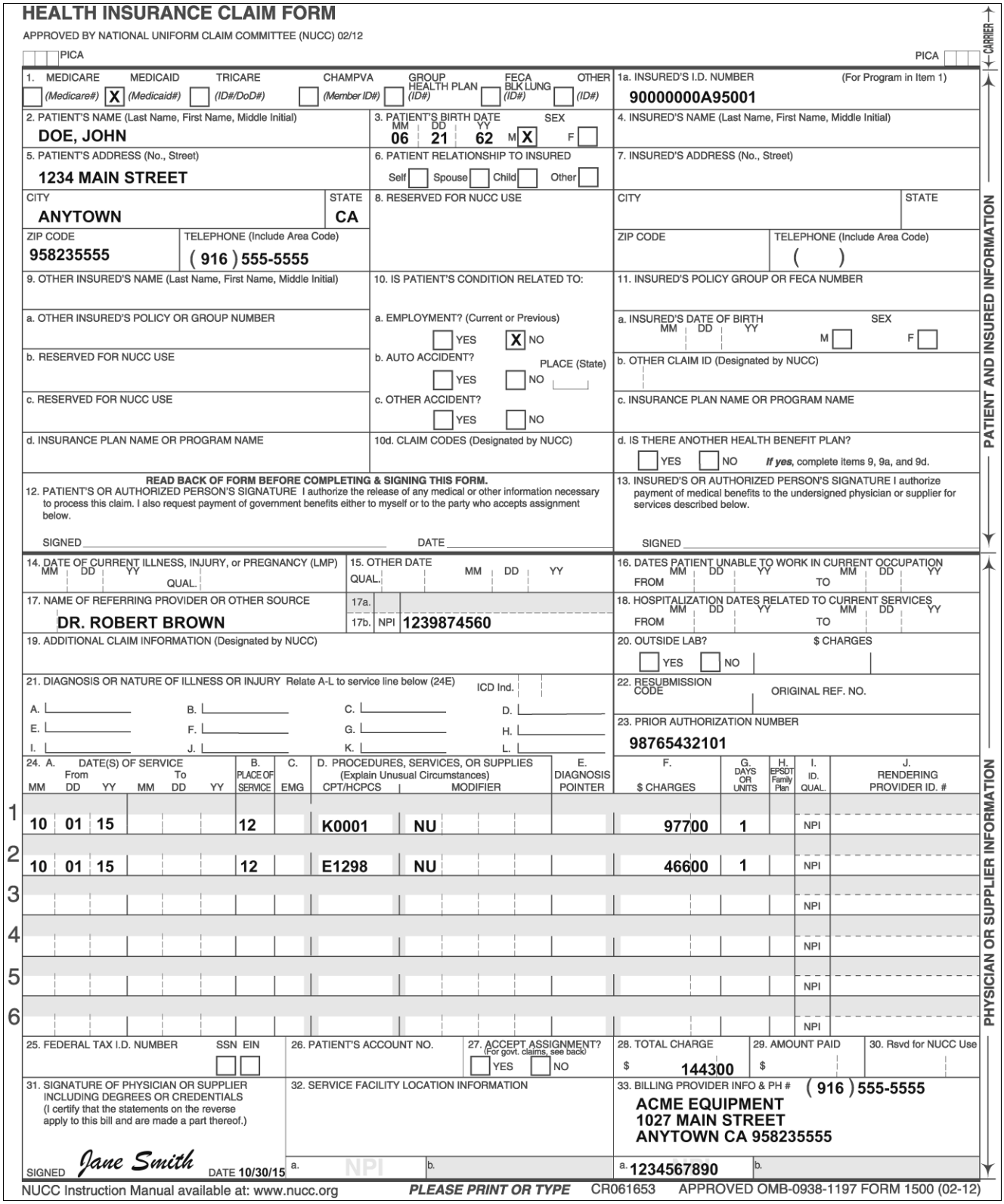
In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all DME rental and purchases.

Because the DME company is billing for a wheelchair exceeding the cumulative cost of $100, authorization is required; therefore, the *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

The DME company is billing for the purchase of a standard wheelchair and an extra wide seat. HCPCS codes K0001 (standard wheelchair) and E1298 (special wheelchair seat) are billed with modifier NU (new equipment purchase) and entered in the *Procedures, Services or Supplies* field (Box 24D).

Wheelchairs, their modifications and/or accessories are nontaxable.

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

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: 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 _____

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. ROBERT BROWN

17a.

17b. NPI 1239874560

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

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: 98765432101

	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				12		K0001	NU		97700	1		NPI	
2	10	01	15				12		E1298	NU		46600	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 $ 144300

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1 Listed DME.

Wheelchair Batteries, Replacement Parts and Labor

Figure 2. Wheelchair batteries, replacement parts and labor.

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

In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17b) because a written prescription is required for all DME rental and purchases.

Claims for labor (HCPCS code K0739) require specific documentation. The statement "repair of patient-owned K0011" is entered in the *Additional Claim Information* field (Box 19). This box should also include the name of the qualified rehabilitation professional who was directly involved in determining the specific wheelchair equipment needs of the patient and who was directly involved with or closely supervised the final fitting and delivery of the wheelchair. For further information about these requirements, see the *Durable Medical Equipment (DME): Bill for Wheelchair and Wheelchair Accessories* section in this manual.

If the cumulative cost of DME items within a group exceeds $100 for purchased items (for example, code E2360, batteries) and/or $250 for repair parts (for example, code K0011), authorization is required and the authorization number is entered in the *Prior Authorization Number* field (Box 23).

The DME company is billing for wheelchair batteries, unlisted replacement parts and labor. HCPCS codes E2360 (22 NF non-sealed lead acid battery), code K0011 (standard weight frame motorized/power wheelchair), code K0739 (labor component) and code E2211 (pneumatic tire) are entered in the *Procedures, Services or Supplies* field (Box 24D). Code E2360 is billed with modifier NU (new equipment purchase) and code K0011 is billed with RB (repair). Claims for labor must include code K0739. Claims for replacement items such as code E2211 must have modifiers RB and NU on the same line.

Because the unlisted wheelchair replacement part(s) is billed with the unlisted code K0011, which is reimbursed "By Report," an attached catalog page(s) is required for pricing information.

Labor is billed in units of 15 minutes per unit; therefore, "2" is entered in the *Days or Units* field (Box 24G) on the claim line for code K0739 to indicate that 30 minutes of labor are being billed.

HEALTH INSURANCE CLAIM FORM

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

PICA

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: 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 _____

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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): MARK BLACK, RESNA. REPAIR OF PATIENT-OWNED K0011.

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: 98765432101

	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				12		E2360	NU		20000	2		NPI	
2	10	01	15				12		K0011	RB		25750	2		NPI	
3	10	01	15				12		K0739			4500	2		NPI	
4	10	01	15				12		E2211	RB NU		8300	1		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 $ 58550

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 2: Wheelchair Batteries, Replacement Parts and Labor.

Rental of an Infant Apnea Monitor

Figure 3. Rental of an infant apnea monitor.

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

Refer to the *Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment* section of this manual for detailed policy information about infant monitors and related supplies.

In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all DME rental and purchases.

The rental of an infant apnea monitor requires authorization; therefore, the *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

Because the infant apnea monitor is rented, it is billed with HCPCS code E0618 (apnea monitor) and modifier RR (rental). This information is entered in the *Procedures, Services or Supplies* field (Box 24D).

Note: All supplies for the monitor are included in the rental reimbursement rate of the monitor and will not be reimbursed separately.

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

Monitors are rented on a monthly basis; therefore, the number of months being billed (for example, ”1”) is entered in the *Days or Units* field (Box 24G) for HCPCS code E0618.

HEALTH INSURANCE CLAIM FORM

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

PICA

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 15 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 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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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: 98765432101

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			12		E0618	RR		24000	1		NPI	
2														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 $ 24000

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3: Rental of Infant Apnea Monitor.

Purchase of an Infant Apnea Monitor

Figure 4. Purchase of an infant apnea monitor.

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

In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all DME rental and purchases.

If the item purchased is taxable, this must be noted in the *Additional Claim Information* field (Box 19).

The purchase of an infant apnea monitor requires authorization; therefore, the *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

Because the infant apnea monitor along with related unlisted supplies are being purchased, HCPCS code E0618 (apnea monitor) and the appropriate code(s) for supplies and accessories, along with modifier NU (new equipment purchase), are entered in the *Procedures, Services or Supplies* field (Box 24D).

Because the purchase of an apnea monitor is billed "By Report," an attached catalog page and invoice are required for pricing information.

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

Because one monitor is being purchased, a "1" is entered in the *Days or Units* field (Box 24G) for HCPCS code E0618. A pair of electrodes (A4556) and a pair of lead wires (A4557) are also listed on separate claim lines.

HEALTH INSURANCE CLAIM FORM

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

PICA

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 15 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 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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): THIS IS A TAXABLE ITEM.

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: 98765432101

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			12		E0618	NU		200000	1		NPI	
2	10	01	15			12		A4556	NU		1100	1		NPI	
3	10	01	15			12		A4557	NU		2000	1		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 $ 203100

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 4: Purchase of Infant Apnea Monitor.

Liquid Oxygen System Rentals

Figure 5. Rental of portable and stationary liquid oxygen systems.

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

This example shows the rental of a stationary liquid oxygen system (E0439RR), the rental of a portable liquid oxygen system (E0434RR), and the purchase of one month's supply of portable liquid oxygen contents (E0444) to fill the portable liquid oxygen system.

In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field(Box 17) and *NPI* field (Box 17B) because a written prescription is required for all oxygen equipment rentals, purchases, and supplies.

All oxygen equipment and supplies require authorization; therefore, the *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

Stationary Liquid Oxygen System

Line 1 of the *Procedures, Services, or Supplies* field (Box 24D) shows billing for the rental of a stationary liquid oxygen system (E0439RR). The description for code E0439 includes oxygen "contents", so billing for any liquid oxygen contents for this system would be inappropriate and not separately reimbursable.

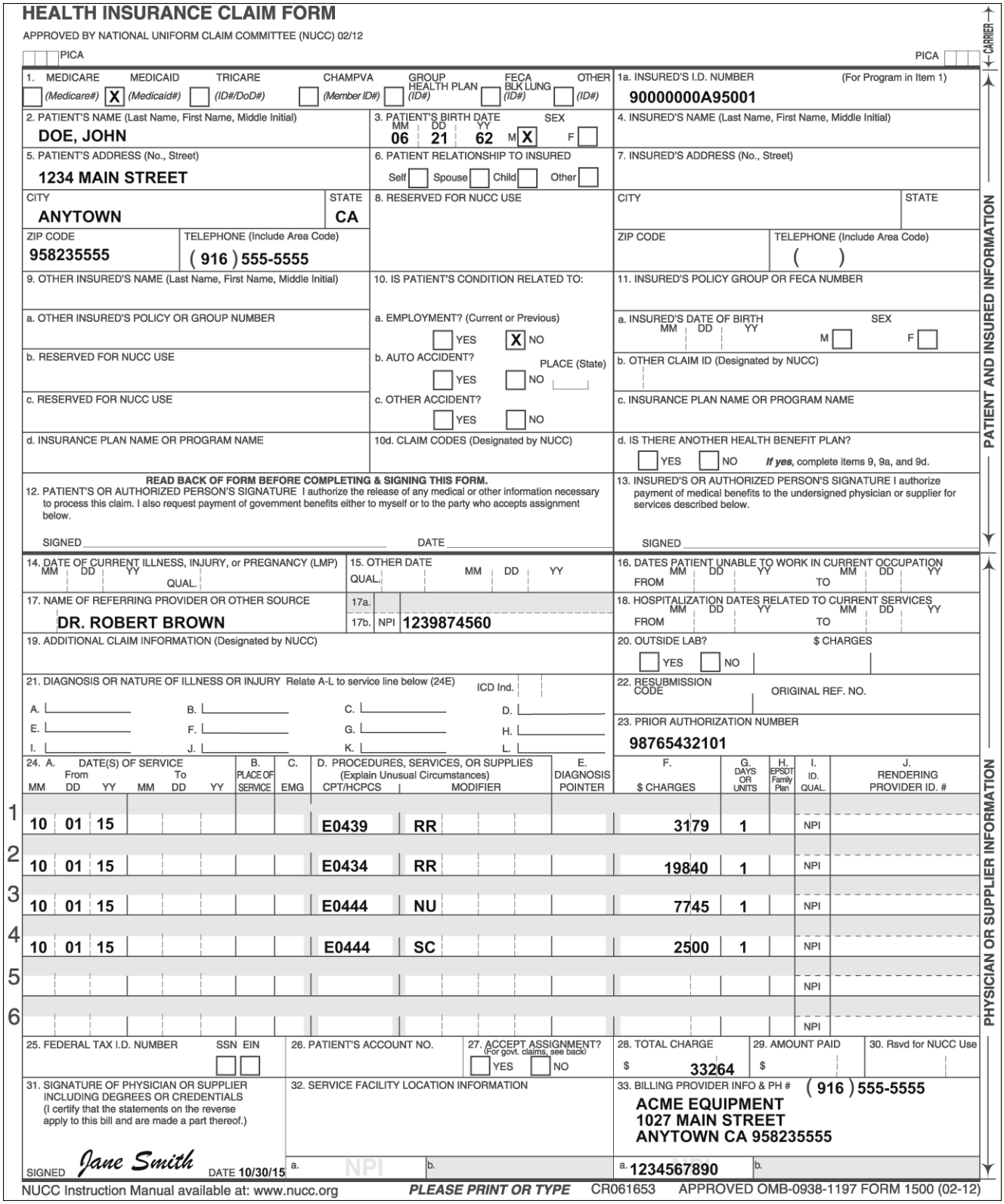
Portable Liquid Oxygen System

Line 2 of the *Procedures, Services, or Supplies* field (Box 24D) reflects billing for the rental of a portable liquid oxygen system (E0434RR).

Portable Liquid Oxygen Contents

Lines 3 and 4 of the *Procedures, Services, or Supplies* field (Box 24D) list one month's supply of portable liquid contents (E0444) to fill the portable liquid oxygen system (for code E0434RR). The first supply (for 110 pounds) is billed with modifier NU (E0444NU) and a quantity of 1 in the *Days or Units* field (Box 24G). The second supply (for any amount exceeding the initial 110 pounds) is billed with modifier SC (E0444SC) and a quantity of 1 in the *Days or Units* field (Box 24G). The billed quantities of lines 3 and 4 **together** are a total of 2 units.

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

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 _____

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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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: 98765432101

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					E0439	RR		3179	1		NPI	
2	10	01	15					E0434	RR		19840	1		NPI	
3	10	01	15					E0444	NU		7745	1		NPI	
4	10	01	15					E0444	SC		2500	1		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 $ 33264

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 5: Rental of Portable and Stationary Liquid Oxygen Systems.

Gas Oxygen System Rental with Modified Oxygen Flow

Figure 6. Rental of stationary gas oxygen system.

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

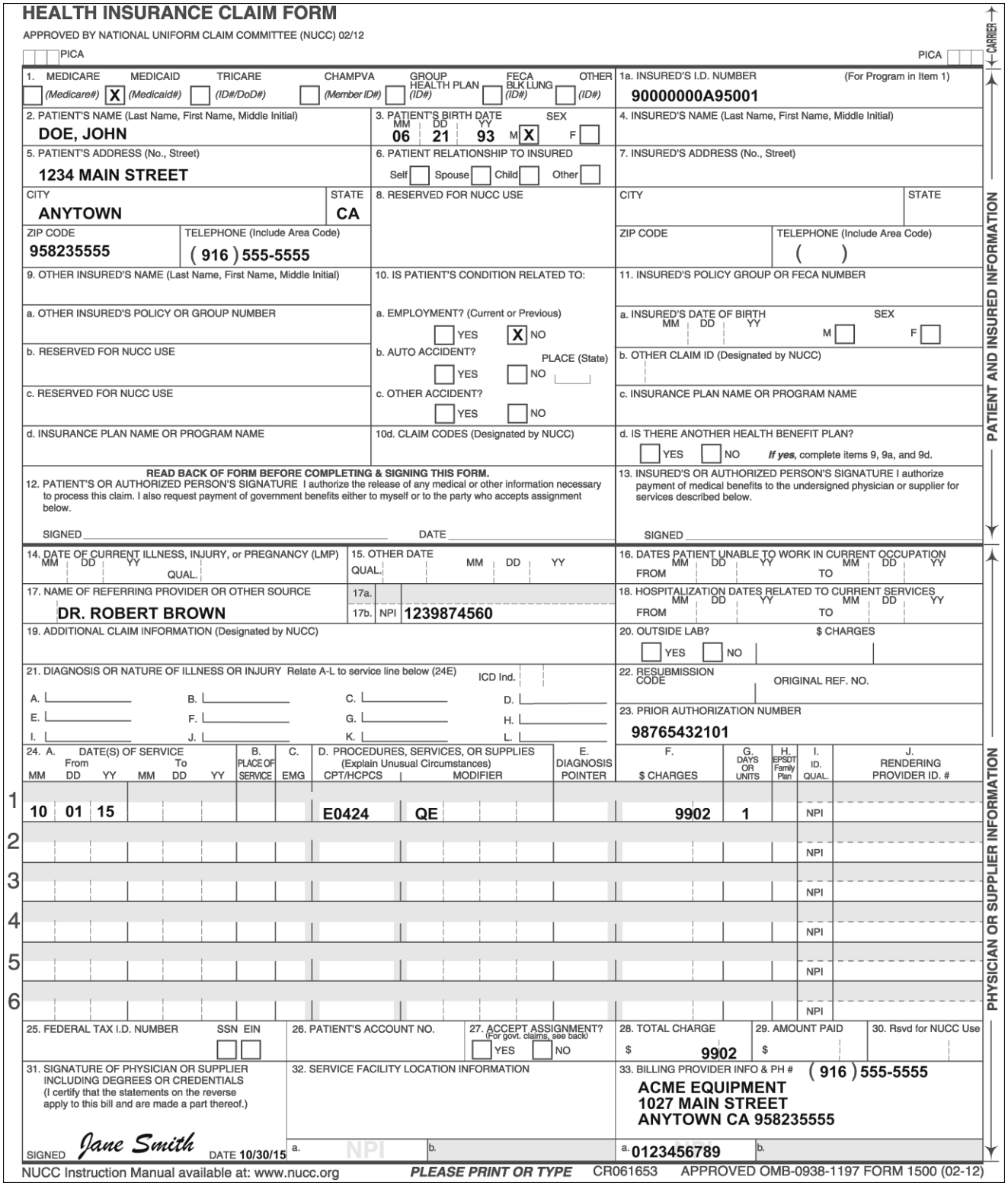
This example shows the rental of stationary gas oxygen system at less than 1 liter per minute oxygen flow rate (E0424QE).

In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all oxygen equipment rentals, purchases, and supplies.

All oxygen equipment and supplies require authorization; therefore, the *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

The code for the rental of a stationary gas oxygen system (E0424) is entered in the *Procedures, Services, or Supplies* Box 24D. Because the prescribed oxygen flow rate to be delivered by the stationary gas oxygen system is less than 1 liter per minute (LPM), code E0424 is billed with modifier QE.

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

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 93 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 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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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: 98765432101

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				E0424	QE		9902	1		NPI	
2										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 $ 9902

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 6: Rental of Stationary Gas Oxygen System.

Oxygen Concentrator with Modified Oxygen Flow and Portable Gas Oxygen System Rental

Figure 7. Rental of oxygen concentrator and rental of portable gas oxygen system.

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

This example shows the rental of an oxygen concentrator at greater than 4 liters per minute flow rate (E1390QF), the rental of a portable gas system (E0431RR), and the purchase of one month's supply of portable gas oxygen contents (E0443) to fill the portable gas oxygen system.

In this example, the referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all oxygen equipment rentals, purchases, and supplies.

All oxygen equipment and supplies require authorization; therefore, the *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

Concentrator

Line 1 of the *Procedures, Services, or Supplies* field (Box 24D) shows the rental of a single delivery port oxygen concentrator (E1390). Because the prescribed oxygen flow rate to be administered by the concentrator is greater than 4 liters per minute (LPM), code E1390 is billed with modifier QF.

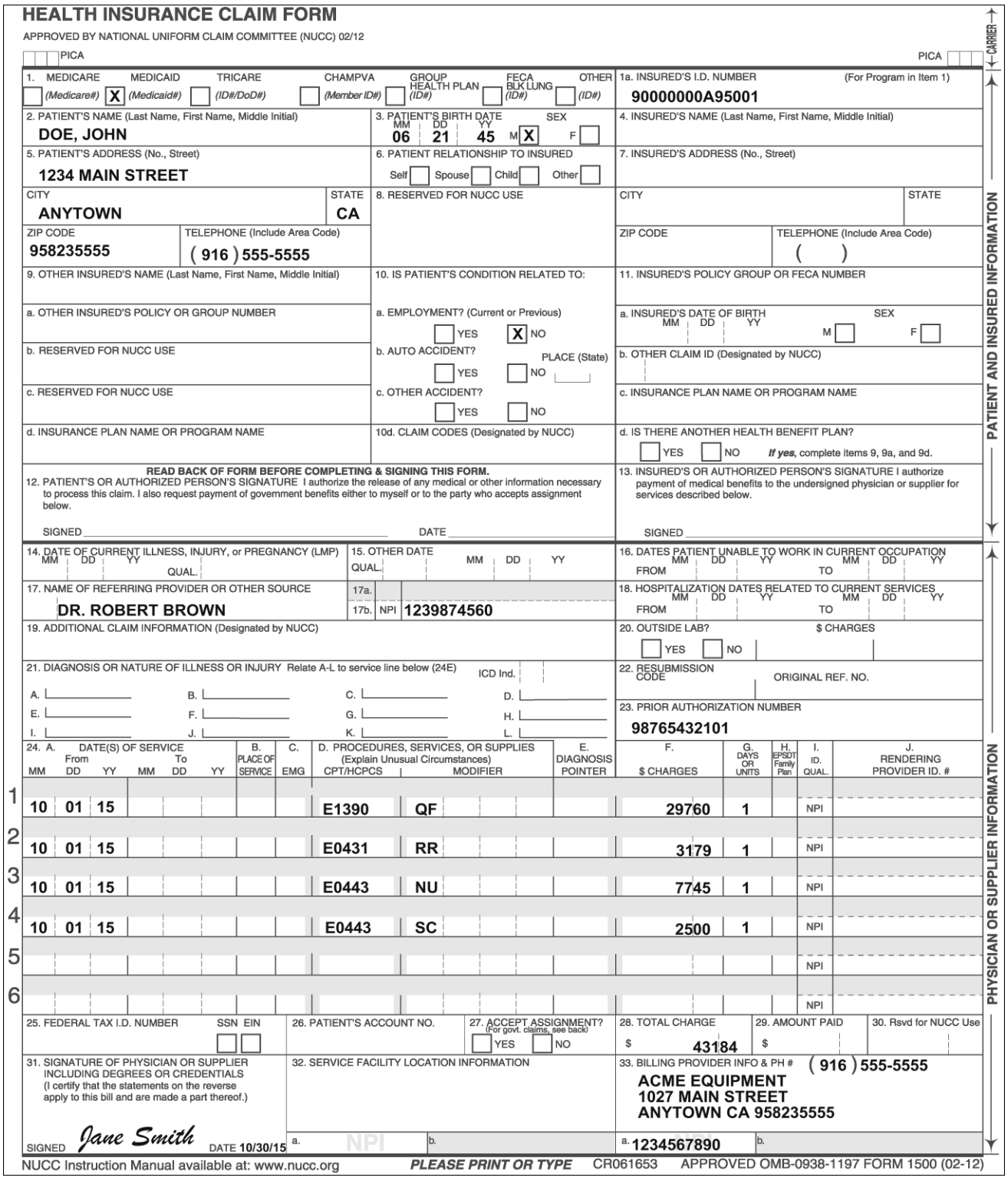
Portable Gas Oxygen System

Line 2 of the *Procedures, Services, or Supplies* field (Box 24D) reflects billing for the rental of a portable gas oxygen system (E0431RR).

Portable Gas Oxygen Contents

Lines 3 and 4 of the *Procedures, Services, or Supplies* field (Box 24D) list one month's supply of portable gas contents (E0443) to fill the portable gas oxygen system (E0431RR). The first supply (for 250 cubic feet) is billed with modifier NU (E0443NU) and a quantity of 1 in the *Days or Units* field (Box 24G). The second supply (for any amount exceeding the initial 250 cubic feet) is billed with modifier SC (E0443SC) and a quantity of 1 in *the Days or Units* field (Box 24G). The billed quantities of lines 3 and 4 **together** are a total of 2 units.

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

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 45 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? PLACE (State) YES [ ] NO [ ]

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 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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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: 98765432101

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				E1390	QF		29760	1		NPI	
2 10 01 15				E0431	RR		3179	1		NPI	
3 10 01 15				E0443	NU		7745	1		NPI	
4 10 01 15				E0443	SC		2500	1		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 $ 43184

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 7: Rental of Oxygen Concentrator and Portable Gas Oxygen System.

“From-Through” Billing for Rental of an Antidecubitus Support Bed

Figure 8. “From-Through” billing for rental of an antidecubitus support bed.

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

In this example, the referring physician’s name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all DME rental and purchases.

If the cumulative cost of DME items within a group exceeds $50 within a 15-month period for rental, authorization is required and the *Treatment Authorization Request* (TAR) number must be entered in the *Prior Authorization Number* field (Box 23).

An antidecubitus support bed is being rented on a daily basis. HCPCS code E0193 (powered air flotation bed [low air loss therapy] [daily rental]) and the modifier RR (equipment rental) are entered in the *Procedures, Services or Supplies* field (Box 24D).

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

When billing for more than one day of service for antidecubitus support beds, use the “from-through” (block-billing) method. Enter the total number of days, which in this case is six, in the *Days or Units* field (Box 24G).

HEALTH INSURANCE CLAIM FORM

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

PICA

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 _____

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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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: 98765432101

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	10	10	15	12		E0193	RR		30000	10		NPI	
2															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 $ 30000

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 Smith DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 8: "From-Through" Billing for Rental of an Antidecubitus Support Bed.

“By Report” DME Billing Requiring Catalog Page Attachment

Figure 9. “By Report” Wheelchair.

Figure 10. Completed Sample Attachment

Figure 11. Sample Invoice.

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

In the following example, a DME provider is billing for the purchase of unlisted wheelchair equipment. The example applies to items listed in a manufacturer’s catalog.

Claim Form Example with Attachment

In this example, a DME provider is billing for the purchase of an unlisted power wheelchair *(Figure 9).* HCPCS codes K0868 (power wheelchair group 4) and K0669 (wheelchair accessory, seat or back cushion), and K0108 (wheelchair component), along with NU modifiers (new equipment purchase) are entered on lines 1, 2 and 3 of the *Procedures, Services or Supplies* field (Box 24D).

Other Requirements

If the billed items appear on an undated catalog page, the cover page or back page from that catalog with the date must also be attached.

Providers should list the name of the qualified rehabilitation professional (as applicable) who was directly involved in determining the specific wheelchair equipment needs of the patient and who was directly involved with or closely supervised the final fitting and delivery of the wheelchair in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim or on an attachment. For further information about these requirements, see the *Durable Medical Equipment* (DME): *Bill for Wheelchair and Wheelchair Accessories* section in this manual.

The amount entered under *Charges* (Box 24F) should be the usual and customary charge. For more information about allowable billing rates, see the *Durable Medical Equipment (DME): Bill for DME* section in this manual.

HEALTH INSURANCE CLAIM FORM

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

PICA

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: 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

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: DR. ROBERT BROWN

17a.

17b. NPI 1239874560

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): MARK BLACK, RESNA.

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: 98765432101

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		12		K0868	NU		727500	1		NPI	
2 10 01 15		12		K0669	NU		40000	1		NPI	
3 10 01 15		12		K0108	NU		15000	1		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 $ 782500

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 Smith* DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5644
CALIFORNIA EQUIPMENT CO.
1234 ANY STREET
ANYTOWN CA 958235555

a. 1234567890 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Figure 9: "By Report" Wheelchair

BT POWER WHEELCHAIRS & ACCESSORIES
Price List and Order Form

Effective October 1, 2015

BT Wheelchairs
101 Bold Way
Middletown, CA 12345
800-555-4433

Company Name California Equipment Co. **Account #** CE123456

Phone # 916-555-5644 **P.O. #** _____ **Date** _____

Ship To Name & Address 1234 Any Street, Anytown CA 95823

Chair Type	Description	Suggested Retail Price
☐ BT Pwr BSX	Base & Seat w/o Electronics	$ 5,885.00
☒ BT Pwr SXE	Base & Seat w/ Electronics	7,275.00
☐ BT Pwr BX	Base Only w/o Electronics	4,790.00
☐ BT Pwr BXE	Base Only w/ Electronics	6,435.00
Seat Selection		
☐ ASBA	Seat w/ Adjustable Tilt & Back Angle	no charge
☐ RECL	Recliner	649.00
ASBA Frame Width		
☐ FW 12	12" Wide	no charge
☐ FW 14	14" Wide	no charge
☐ FW 16	16" Wide	no charge
☐ FW 20	20" Wide	290.00
☐ FW 22	22" Wide	290.00
ASBA Seat Depth		
☐ SD 12	12" Seat Depth	no charge
☐ SD 14	14" Seat Depth	no charge
☐ SD 16	16" Seat Depth	no charge
☐ SD 20	20" Seat Depth	490.00
☐ SD 22	22" Seat Depth	490.00
Arm Style		
☐ A-FL 1	Full Length Fixed Height Convertible Flip Up	no charge
☐ A-DL 1	Desk Length Fixed Height Convertible Flip Up	no charge
Cushion		
☐ AB 01	16" Cushion	400.00
☒ AB 02	18" Cushion	400.00
☐ AB 03	20" Cushion	450.00
☐ AB 04	22" Cushion	450.00
Accessories		
☒ TD 01	Transport Tie Down	150.00

Page 1

Figure 10: Completed Sample Attachment

INVOICE NO: DLO9876543
ORDER NO: 00112233445
DATE: **10/1/2015**

BT Wheelchairs
101 Bold Way
Middletown, CA 12345
800-555-4433

BILL TO:
California Equipment Co.
1234 Any Street
Anytown, CA 95823
916-555-5644

SHIP TO:
California Equipment Co.
1234 Any Street
Anytown, CA 95823
916-555-5644

DATE	ITEM #	DESCRIPTION	QTY	TOTAL
10/1/15	BT Pwr SXE	Base & Seat w/Electronics	1	$4,275.00
10/1/15	TD 01	Transport Tie Down	1	$50.00
10/1/15	AB 02	Cushion	1	$150.00

TOTAL DUE: $4,475.00

Figure 11: Sample Invoice

‹‹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.