# **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).

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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.

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	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
	DOE, JOHN	06 21 62 MX F		
	5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
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			ANYTOWN CA 958235555	
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İ	NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE CRO	061653 APPROVED OMB-0938-1197 FORM 1500 (0	)2-12)

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		
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1234 MAIN STREET	Self Spouse Child Other	
ANYTOWN CA	8. RESERVED FOR NUCC USE	CITY
ZIP CODE         TELEPHONE (Include Area Code)           958235555         ( 916 ) 555-5555		ZIP CODE TELEPHONE (Include Area Code)
958235555 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)	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	YES         NO           10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES NO If yes, complete items 9, 9a, and 9d.
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		\$         24000         \$           33. BILLING PROVIDER INFO & PH #         (916) 555-5555
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		ACME EQUIPMENT 1027 MAIN STREET ANYTOWN CA 958235555
SIGNED Jane Smith DATE 10/30/15 a.	DI b.	a.1234567890 b.
SIGNED DATE 10/30/15 a.		

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.

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5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
1234 MAIN STREET	Self         Spouse         Child         Other           8. RESERVED FOR NUCC USE	CITY STATE
ANYTOWN CA	8. RESERVED FOR NUCC USE	SIATE
ZIP CODE         TELEPHONE (Include Area Code)           958235555         ( 916 ) 555-5555		ZIP CODE TELEPHONE (Include Area Code)
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	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLETIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the to process this claim. I also request payment of government benefits either below.	release of any medical or other information necessary	<ol> <li>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</li> </ol>
SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. MM   DD   YY   QUAL   QU	OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 176		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DR. ROBERT BROWN 17t	D. NPI <b>1239874560</b>	FROM TO 20. OUTSIDE LAB? \$ CHARGES
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) THIS IS A TAXABLE ITEM.		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to serv	vice line below (24E) ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
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10 01 15   12   A4557	7 NU	2000 1 NPI
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		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S /	ACCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use \$ 203100 \$
SILSIGNATURE 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.)		33. BILLING PROVIDER INFO & PH # (916) 555-5555 ACME EQUIPMENT 1027 MAIN STREET ANYTOWN CA 958235555
SIGNED Jane Smith DATE 10/30/15 a. N	þ.	<sup>a.</sup> 1234567890 <sup>b.</sup>
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE CR	061653 APPROVED OMB-0938-1197 FORM 1500 (02-12

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			*
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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).

(Medicare#)       (Medicaid#)       (ID#/DOD#)       (Member ID#)       HEALTH PLAN       BLK LUNG       (ID#)       90000000A95001         2. PATIENT'S NAME (Last Name, First Name, Middle Initial)       3. PATIENT'S BIRTH DATE       SEX       4. INSURED'S NAME (Last Name, First Name, Middle Initial)         5. PATIENT'S ADDRESS (No., Street)       6. PATIENT RELATIONSHIP TO INSURED       7. INSURED'S ADDRESS (No., Street)         1234 MAIN STREET       6. PATIENT RELATIONSHIP TO INSURED       7. INSURED'S ADDRESS (No., Street)         CITY       STATE       8. RESERVED FOR NUCC USE       CITY         ZIP CODE       TELEPHONE (Include Area Code)       916) 555-55555       CITY         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	STATE
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I carify 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 ACME EQUIPMENT 1027 MAIN STREET ANYTOWN CA 958235555	5-5555
SIGNED Jane Smith DATE 10/30/15 a. NP b. a. 0123456789 b.	
NUCC Instruction Manual available at: www.nucc.org <b>PLEASE PRINT OR TYPE</b> CR061653 APPROVED OMB-0938-1197 FO	RM 1500 (02-12)

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 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 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).

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

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1. MEDICARE MEDICAID TRICARE CHAMPV	A GROUP FECA OTHER HEALTH PLAN BLK LUNG (ID#) (ID#) (ID#) (ID#)	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
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1234 MAIN STREET	Self Spouse Child Other		
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		\$ 43184 <sup>\$</sup>	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (91 ACME EQUIPMENT 1027 MAIN STREET ANYTOWN CA 958235555	6 ) 555-5555
signed Jane Smith DATE 10/30/15 a. NF	D] b.	<sup>a.</sup> 1234567890 <sup>b.</sup>	
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE CR	061653 APPROVED OMB-0938-1	197 FORM 1500 (02-12)

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

### <u>"From-Through" Billing for Rental of an Antidecubitus Support</u> 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).

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SIGNATURE OF PHY INCLUDING DEGREE (I certify that the state apply to this bill and a	ES OR CRI ments on t	DENTIA	LS	32. 5	BERVICE FA	CILITY I	LOCATI				10	A0 10		QUIPM IN STR	ENT	(0	,	555-55	555
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## "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	PICA
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA	OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) X (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)	( <i>ID#</i> ) 9000000A95001
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN 3. PATIENT'S BIRTH DATE MM DD YY 06 21 62 MX	SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSU	SURED 7. INSURED'S ADDRESS (No., Street)
1234 MAIN STREET Self Spouse Child	Other
CITY STATE 8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	
ZIP CODE         TELEPHONE (Include Area Code)           958235555         ( 916 ) 555-5555	CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER Outs) a. INSURED'S DATE OF BIRTH DD YY M F C. INSURED'S DATE OF BIRTH SEX MM DD YY M F C. INSURANCE PLAN NAME OR PROGRAM NAME O NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELAT	ATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previou	a. INSURED'S DATE OF BIRTH SEX
YES NO	
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT?	PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)
YES NO	
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NI	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	YES NO If yes, complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information to process this claim. I also request payment of government benefits either to myself or to the party who accepts assis below.	on necessary payment of medical benefits to the undersigned physician or supplier for
SIGNED DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTHER DATE	YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
QUAL.     QUAL.       17. NAME OF REFERRING PROVIDER OR OTHER SOURCE     17a.	FROM TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 18. HOSPITALIZATION DATES RELATED TO THE DEVICES MM DD
DR. ROBERT BROWN 17b. NPI 1239874560	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES
MARK BLACK, RESNA.	YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
A B C D	CODE CHIGINAL REP. NO.
E F G H	23. PRIOR AUTHORIZATION NUMBER
I J K L	98765432101
24. A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES From To PLACEOF (Explain Unusual Circumstances) MM DD YY MM DD YY SERVICE EMG CPT/HOPCS   MODIFIER	E. F. G. H. J. J. DAYS EPST DIAGNOSIS POINTER \$ CHARGES UNITS Party OUAL PROVIDER ID. # 7277500 1 NPI 400000 1 NPI
10 01 15 12 K0868 NU	
	727500 1 NPI
10 01 15   12   K0669 NU	40000 1 NPI
10 01 15 12 K0108 NU	15000 1 NPI
	NPI
	NPI
	NPI
	NPI
	NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASS (For gov. claims, YES	SigGNMENT?         28. TOTAL CHARGE         29. AMOUNT PAID         30. Rsvd for NUCC Use           NO         \$ 782500         \$
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASS	SIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use
25. FEDERAL TAX I.D. NUMBER SSN EIN     26. PATIENT'S ACCOUNT NO.     27. ACCEPT ASS     (For gov. clambs,     (For gov. clambs,     (For gov. clambs,     (I certify that the statements on the reverse     apply to this bill and are made a part thereof.)	SIGNMENT?         28. TOTAL CHARGE         28. AMOUNT Pail         30. Revd for NUCC Use           Mo         \$ 782500         \$         30. Revd for NUCC Use           33. BILLING PROVIDER INFO & PH #         (916) 555-5644         CALIFORNIA EQUIPMENT CO.           1234 ANY STREET ANYTOWN CA 958235555         ANYTOWN CA 958235555
	SIGNMENT?         28. TOTAL CHARGE         28. MOUNT Pail         30. Rsvd for NUCC Use           Mo         \$ 782500         \$         30. Rsvd for NUCC Use           NO         \$ 782500         \$         1           33. BILLING PROVIDER INFO & PH #         (916) 555-5644         CALIFORNIA EQUIPMENT CO.           1234 ANY STREET         ANYTOWN CA 958235555         a. 1234567890

ice List and Orde		BT Wheelchairs
fective October 1, 201	J	Middletown, CA 1234 800-555-443
mpany Name <u>Cali</u>	fornia Equipment Co.	Account # <u>CE123456</u>
one # <u>916-555-56</u>	544 P.O. #	Date
ip To Name & Addre	ess 1234 Any Street, Anytown CA 958	323
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
	Recliner	649.00
ASBA Frame Width	10" \A6da	
□ 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
🗆 АВ 04	22" Cushion	450.00
Accessories		
X TD 01	Transport Tie Down	150.00

## Figure 10: Completed Sample Attachment

dura ex 20 Page updated: September 2020

INVOICE NO: DL09876543 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
<u>10/1/15</u>	BT Pwr SXE	Base & Seat w/Electronics	1	\$4,275.00
<u>10/1/15</u>	TD 01	Transport Tie Down	1	\$50.00
<u>10/1/15</u>	AB 02	Cushion	1	\$150.00

TOTAL DUE: \$4,475.00

Figure 11: Sample Invoice

## <u>«Legend»</u>

</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.