
California Children's Services (CCS) Program Billing Example: CMS-1500

Page updated: September 2020

The example in this section assists providers in California Children's Services (CCS) program billing on the *CMS-1500* claim form. The explanations on the following page emphasize billing issues common to all CCS providers – proper use of Service Authorization Request (SAR) numbers, NPI numbers and client ID numbers. Refer to *the CMS-1500 Completion* section in this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the Forms: *Legibility and Completion Standards* section of this manual.

Refer to the *California Children's Services (CCS) Program* section in this manual for policy information.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts, or dollar signs with the charges. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Important Fields for CCS Claim Completion

Figure 1. Completing fields for CCS claims: Service Authorization Request (SAR), NPI and client ID numbers.

This is a sample only. Please adapt to your billing situation. Attachments are not illustrated in this example.

In this example, a physician is billing for surgical procedures rendered at an inpatient hospital. Two CPT® codes are billed with modifiers in the *Procedures, Services or Supplies* field (Box 24D).

Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

Insured's ID Number

Enter the client's identification number in the *Insured's ID Number* field (Box 1A) as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.

Note: «For providers billing without a SAR number with prefix "91" or "97" for CCS-only clients, leave this field blank.»

Authorization Request

Enter the 11-digit SAR number in the *Prior Authorization Number* field (Box 23).

Note: For providers billing without a SAR number with prefix "91" or "97", leave this field blank.

Referring Provider

Enter a referring physician's NPI in Box 17B. If the service was rendered pursuant to a referring physician's SAR, then the SAR number from the referring physician must be included on the claim form. If the services provided were not pursuant to a referring physician's SAR, then leave the *Name of Referring Provider or Other Source* field (Box 17) blank.

Rendering Provider

If the provider is billing with a group NPI, enter the NPI number of the provider who rendered the service in the *Rendering Provider ID Number* field (Box 24J).

Facility Where Services Were Rendered

Because the service is being rendered in an inpatient setting, *the Service Facility Location Information* field (Box 32) must contain the facility information. Enter the NPI in Box 32A.

Billing Provider Information

Enter the billing provider's address and phone number in the *Billing Provider Info and Phone Number* field (Box 33) and an NPI number in Box 33A.

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

Figure 1: Completing Fields for CCS Claims: SAR, NPI and Client ID Numbers.

HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>		
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input checked="" type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		90000000A95001			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
DOE, JANE				06 21 98		M <input type="checkbox"/> F <input checked="" type="checkbox"/>						
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)				
1234 MAIN STREET				Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>								
CITY			STATE			CITY			STATE			
ANYTOWN			CA									
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)						
958235555		(916) 555-5555										
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				
				<input type="checkbox"/> YES <input type="checkbox"/> NO				MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?				b. OTHER CLAIM ID (Designated by NUCC)				
				<input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)								
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME				
				<input type="checkbox"/> YES <input type="checkbox"/> NO								
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
								<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				
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 _____						DATE _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
MM DD YY QUAL				MM DD YY QUAL				FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
				0123456789				FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
PLEASE SEE ATTACHED OPERATIVE REPORT												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												
A. <u>D1D1D1D</u>			B. <u>D2D2D2D</u>			C. _____			D. _____			
E. _____			F. _____			G. _____			H. _____			
I. _____			J. _____			K. _____			L. _____			
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS		F. \$ CHARGES		
From To		MM DD YY MM DD YY				(Explain Unusual Circumstances)		MODIFIER		RENDERING PROVIDER ID. #		
10 01 15		21				42500 AG				200000 1 NPI 1234567890		
2 10 01 15		21				42300 51				50000 1 NPI 1234567890		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX I.D. NUMBER			SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE	
			<input type="checkbox"/>						<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 250000	
29. AMOUNT PAID			30. Rsvd for NUCC Use			31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS			32. SERVICE FACILITY LOCATION INFORMATION			
						(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			
SIGNED <i>John Doe</i>			DATE 10/02/15			a. 2345678901			b. 3456789012			
JANE SMITH			1027 MAIN STREET			ANYTOWN CA 958235555						

<<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.