Eyeglass Lenses Example: CMS-1500

Page updated: August 2020

Examples in this section will help providers bill for eyeglass lenses on the *CMS-1500* claim form. Refer to the *Eyeglass Lenses* section of this manual for policy information. Refer to the *CMS-1500 Completion* for *Vision Care* 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, or dollar signs with the charges. When entering modifiers, do not include hyphens. 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.

Page updated: August 2020

Single Vision Lenses in Lieu of Bifocals

Figure 1. Single vision lenses in lieu of bifocals.

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

In this example, an optometrist who resides in a Prison Industry Authority (PIA) county is billing for two pairs of single vision eyeglasses – one for distance vision and one for near vision – in lieu of bifocals, for a recipient who cannot adapt to bifocals.

Enter “11” in the *Place of Service* field (Box 24B) to indicate that service was rendered in an office. A primary and secondary ICD-10-CM code are entered in the *Diagnosis or Nature of Illness or Injury field* (Box 21).

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.

Note: Prescribing two pairs of eyeglasses in lieu of bifocals for recipients 38 years of age or older is one of the conditions that requires valid ICD-10-CM diagnosis codes to be billed on the claim. Refer to the *Eye Appliances*, *Eyeglass Frames* and *Eyeglass Lenses* sections in this manual for policy and billing instructions.

Because two frames are required for a recipient who has no prior frame, HCPCS code V2020 (frames, purchases) is billed with modifier NU (new equipment) in *the Procedures, Services, or Supplies field* (Box 24D) and quantity “2” in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

In addition, because the recipient resides in a PIA county (Sacramento in this example), only lens dispensing fees (CPT® codes 92340 – 92342 and 92352 – 92353) can be billed. Therefore, CPT code 92340 (fitting of spectacles, except for aphakia; monofocal) is billed. Modifier NU is billed because the recipient has no prior history of ophthalmic lenses. Enter “4” in the *Days or Units* field (Box 24G) to indicate that four monofocal or single vision lenses are being dispensed. Enter the usual and customary charges in the *Charges* field (Box 24F).

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 0

A. D1D1D1D B. D2D2D2D C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15		11		V2020	NU		5000	2		NPI	
2	10 01 15		11		92340	NU		10000	4		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 15000

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Doe* DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

Figure 1. Single Vision Lenses in Lieu of Bifocals for a Recipient 38 Years or Older on the Date of Service.

Bifocals Prescribed for Recipients Younger Than 38 Years of Age

Figure 2. Bifocals prescribed for recipients younger than 38 years of age on the date of service.

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

In this example, an optometrist, who resides in a PIA county, has prescribed bifocal lenses for a 10-year old child.

Enter "11" in the Place of Service field (Box 24B) to indicate that service was rendered in an office. A primary ICD-10-CM code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

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.

Note: Prescribing multifocal for recipients younger than 38 years of age on the date of service is one of the conditions that require specified ICD-10-CM diagnosis codes to be billed as a primary diagnosis on the claim. Refer to the *Eye Appliances, Eyeglass Frames and Eyeglass Lenses* sections in this manual for policy and billing instructions.

Because one frame is required for a recipient who has none prior, HCPCS code V2020 (frames, purchases) is billed with modifier NU (new equipment) in the *Procedures, Services, or Supplies* field (Box 24D) and quantity "1" in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

In addition, because the recipient resides in a PIA county (Sacramento in this example), only lens dispensing fees (CPT codes 92340 – 92342 and 92352 – 92353) can be billed. Therefore, CPT code 92341 (fitting of spectacles, except for aphakia; bifocal) is billed. Modifier NU is billed since the recipient has no prior history of ophthalmic lenses. Enter "2" in the *Days or Units* field (Box 24G) to indicate that two bifocal lenses are being dispensed. Enter the usual and customary charges in the *Charges* field (Box 24F).

Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete remaining fields on the claim.

Page updated: August 2020

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | 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 82 — 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 [X] 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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 0

A. D1D1D1D — B. — C. — D.
E. — F. — G. — H.
I. — J. — K. — L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	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		11		V2020	NU		5000	1		NPI	
2	10 01 15		11		92341	NU		10000	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 $ 15000

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Doe* DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION — a. NPI — b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 — b.

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Figure 2: Bifocals Prescribed for Recipients Younger Than 38 Years of Age on the Date of Service

Eyeglass Replacement: Previous Lenses Less Than Two Years Old

Figure 3. Eyeglass replacement: Previous eyeglasses are less than two years old.

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

In this example, an optometrist, who resides in a PIA county, is billing for a replacement pair of bifocal eyeglasses. Previous eyeglasses, that were ordered less than two years ago, are lost. The optometrist has obtained a signed statement from the recipient about the circumstances for replacement to keep in the medical record.

Enter “11” in the *Place of Service* field (Box 24B) to indicate that service was rendered in an office. A primary ICD-10-CM code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Enter secondary diagnosis code(s), if applicable, on lines A, B, C etc., of Box 21.

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.

Because one replacement frame is required for the recipient, HCPCS code V2020 (frames, purchases) is billed with modifier RA (replacement) in the *Procedures, Services, or Supplies* field (Box 24D) and quantity “1” in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

In addition, because the recipient resides in a PIA County (Sacramento in this example), only lens dispensing fees (CPT codes 92340 – 92342 and 92352 – 92353) can be billed. Therefore, CPT code 92341 (fitting of spectacles, except for aphakia; bifocal) is billed. Modifier RA is billed to indicate that the optometrist is replacing the lenses for the recipient. Enter “2” in the *Days or Units* field (Box 24G) to indicate that two bifocal lenses are being dispensed. Enter the usual and customary charges in the *Charges* field (Box 24F).

Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete remaining fields on the claim.

Refer to the *Eye Appliances, Eyeglass Frames and Eyeglass Lenses* sections in this manual for policy and billing instructions.

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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. 0

A. D1D1D1D B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Line	24A. From MM	DD	YY	To MM	DD	YY	B. Place of Service	C. EMG	D. 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				11		V2020	RA		5000	1		NPI	
2	10	01	15				11		92341	RA		10000	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 $ 15000

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Doe DATE 10/30/15

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

PHYSICIAN OR SUPPLIER INFORMATION

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

Figure 3: Eyeglass Replacement: Previous Eyeglasses are Less Than Two Years Old.

‹‹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.