
Non-Physician Medical Practitioners (NMP) Billing

Example: CMS-1500

Page updated: August 2020

This section is to assist providers in completing the CMS-1500 claim when a Non-Physician Medical Practitioner (NMP) renders services. Refer to the *Non-Physician Medical Practitioners (NMP)* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of 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.

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 x 11-inch sheet of paper and attach it to the claim.

NMP-Rendered Service

Figure 1. Billing for NMP-rendered service.

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

In this example, a Certified Nurse Midwife (CNM) is administering a Tetanus toxoid injection (HCPCS code X6954). Enter code X6954 with modifier SB (indicating the service was rendered by a CNM) in the *Procedures, Services or Supplies* field (Box 24D).

CNM services are billed by and will be reimbursed to the CNM's supervising physician, who in this case is a member of a group (Medical Alternatives). The supervising physician's NPI is entered in the *Rendering Provider ID* field (Box 24J). The group name is entered in the *Billing Provider Info and Phone Number* field (Box 33) and NPI 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.

Enter the NMP's name, NPI and type of NMP (for example, PA, CNM, NP) in the *Additional Claim Information* field (Box 19).

In the *Date(s) of Service* field (Box 24A), the date of the office visit is entered on claim line 1 in the six-digit format. Enter Place of Service code 11 (office) in Box 24B.

Enter the date of the injury that resulted in the need for the tetanus injection in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14). This information is optional but facilitates claim processing.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for code X6954.

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.

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) DOE, JOHN				3. PATIENT'S BIRTH DATE MM DD YY 06 21 62		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			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) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
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 10 01 15 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) SUE SMITH CNM. NPI: 0123456789						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0						22. RESUBMISSION CODE ORIGINAL REF. NO.						
A. D1D1D1D		B. _____		C. _____		D. _____		E. _____		23. PRIOR AUTHORIZATION NUMBER		
E. _____		F. _____		G. _____		H. _____		I. _____				
I. _____		J. _____		K. _____		L. _____						
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. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 01 15		11		X6954 SB				1200	1	NPI	1234567890	
										NPI		
										NPI		
										NPI		
										NPI		
										NPI		
										NPI		
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1200	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 <i>Jane Doe</i> DATE 10/30/15				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				33. BILLING PROVIDER INFO & PH # (916) 555-5555 MEDICAL ALTERNATIVES 1444 44TH STREET ANYTOWN CA 958235555 a. 2345678901 b. _____				

Figure 1: NMP-Rendered Service: Tetanus Injection by Certified Nurse Midwife

<<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.