
Professional Services Examples: CMS-1500

Page updated: September 2020

Examples in this section will help providers bill for professional services on the *CMS-1500* claim form. Refer to the *Professional Services* 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, dollar amounts or dollar signs with the charges. If requested information does not fit neatly in the *Additional Claim Information* (Box 19) of the *CMS-1500* claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Interim Comprehensive Eye Examination

Figure 1. Interim comprehensive eye examination.

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

In this example, an optometrist is billing for a comprehensive eye examination for a recipient that last received services within the 24-month benefit period.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that services were rendered in an office. An 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: A valid ICD-10-CM diagnosis code is required when billing for a comprehensive eye examination within the 24-month benefit period.

CPT® code 92014 (ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, one or more visits) is billed on line 1 of the *Procedures, Services, or Supplies* field (Box 24D) for the comprehensive eye examination. Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

If the refraction test was performed, enter CPT code 92015 (determination of refractive state) in the *Procedures, Services, or Supplies* field (Box 24D). Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

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 *Professional Services* section in this manual for policy information.

Refer to the *Professional Services: Diagnosis Codes* section in this manual for a list of required ICD-10-CM codes when billing for an additional comprehensive eye examination within the 24-month benefit period.

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> 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 <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 type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F			
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 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 _____			
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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				22. RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0				23. PRIOR AUTHORIZATION NUMBER							
A. D1D1D1D		B. _____		C. _____		D. _____		F. \$ CHARGES		J. RENDERING PROVIDER ID. #	
E. _____		F. _____		G. _____		H. _____		G. DAYS OR UNITS		I. ID. QUAL.	
I. _____		J. _____		K. _____		L. _____		H. EPSTI Family Plan			
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			
1 10 01 15		11				92014				10000 1 NPI	
2 10 01 15		11				92015				3000 1 NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 13000	
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.) <i>Jane Doe</i> SIGNED DATE 10/30/15			
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. 0123456789				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555							

Figure 1: Interim Comprehensive Eye Examination.

Out-of-Office Call

Figure 2. Out-of-office call.

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

In this example, an optometrist is providing a comprehensive eye examination for a recipient in an inpatient hospital. Because the patient was seen in an inpatient hospital, the optometrist is billing CPT code 99056 (services provided at request of patient in a location other than the physician's office, which are normally provided in the office) in addition to the comprehensive eye exam (CPT code 92004).

Enter "21" in the *Place of Service* field (Box 24B) to indicate that services were rendered in an inpatient hospital.

In this example an 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.

CPT code 92004 (ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits) is billed on line 1 of the *Procedures, Services, or Supplies* field (Box 24D) for the comprehensive eye examination. Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

Since the services were performed at an inpatient hospital, enter CPT code 99056 in the *Procedures, Services, or Supplies* field (Box 24D). Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity "1" in the *Days or Units* field (Box 24G).

The optometrist has written, "Justification attached to claim" in the *Additional Claim Information* field (Box 19), indicating the required justification letter for an out-of-office call is attached to the claim.

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

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>				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 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 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.											
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) MM DD YY QUAL.											
15. OTHER DATE MM DD YY QUAL.											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE											
17a. NPI											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
JUSTIFICATION ATTACHED TO CLAIM											
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.											
24. A. DATE(S) OF SERVICE To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #											
1 10 01 15 21 92004 10000 1 NPI											
2 10 01 15 21 99056 2000 1 NPI											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (916) 555-5555											
SIGNED <i>Jane Doe</i> DATE 10/30/15 a. NPI b. a. 0123456789 b.											
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Figure 2: Out-of-Office Call.

Visual Field Examination

Figure 3. Visual Field Examination.

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

In this example, an optometrist is billing for a visual field examination.

Enter “11” in the *Place of Service* field (Box 24B) to indicate that services were rendered in an office.

In this example an 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: A valid ICD-10-CM code is required when billing for a visual field examination.

CPT code 92083 (visual field examination, unilateral or bilateral, with interpretation and report; extended examination) is billed on line 1 of the *Procedures, Services, or Supplies* field (Box 24D) for the visual field examination. Enter the usual and customary charges in the *Charges* field (Box 24F) and quantity “1” in the *Days or Units* field (Box 24G).

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 *Professional Services* section in this manual for policy information.

Refer to the *Professional Services: Diagnosis Codes* section in this manual for a list of required ICD-10-CM codes when billing for a visual field examination.

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> PICA </div> </div>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>						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"/>		
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		
ZIP CODE 958235555			TELEPHONE (Include Area Code) (916) 555-5555			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input 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			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 QUAL.						15. OTHER DATE MM DD YY QUAL.			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. 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? <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											
A. D1D1D1D B. 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) OPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #											
1 10 01 15 11 92083 5000 1 NPI											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>											
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO											
28. TOTAL CHARGE \$ 5000 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											
33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555											
a. 0123456789 b.											

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Figure 3: Visual Field Examination.

«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.