Pregnancy Examples: CMS-1500

Page updated: August 2020

Examples in this section are to help providers bill for pregnancy services on the *CMS-1500* claim form. Refer to the Pregnancy sections 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 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 x 11-inch sheet of paper and attach it to the claim.

Pregnancy Care: Billing

When billing for any medically necessary service during pregnancy or the postpartum period, providers should include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

Per-Visit Billing of a Vaginal Delivery and Antepartum Office Visit

Figure 1. Per-Visit Billing of a Vaginal Delivery and Antepartum Office Visit.

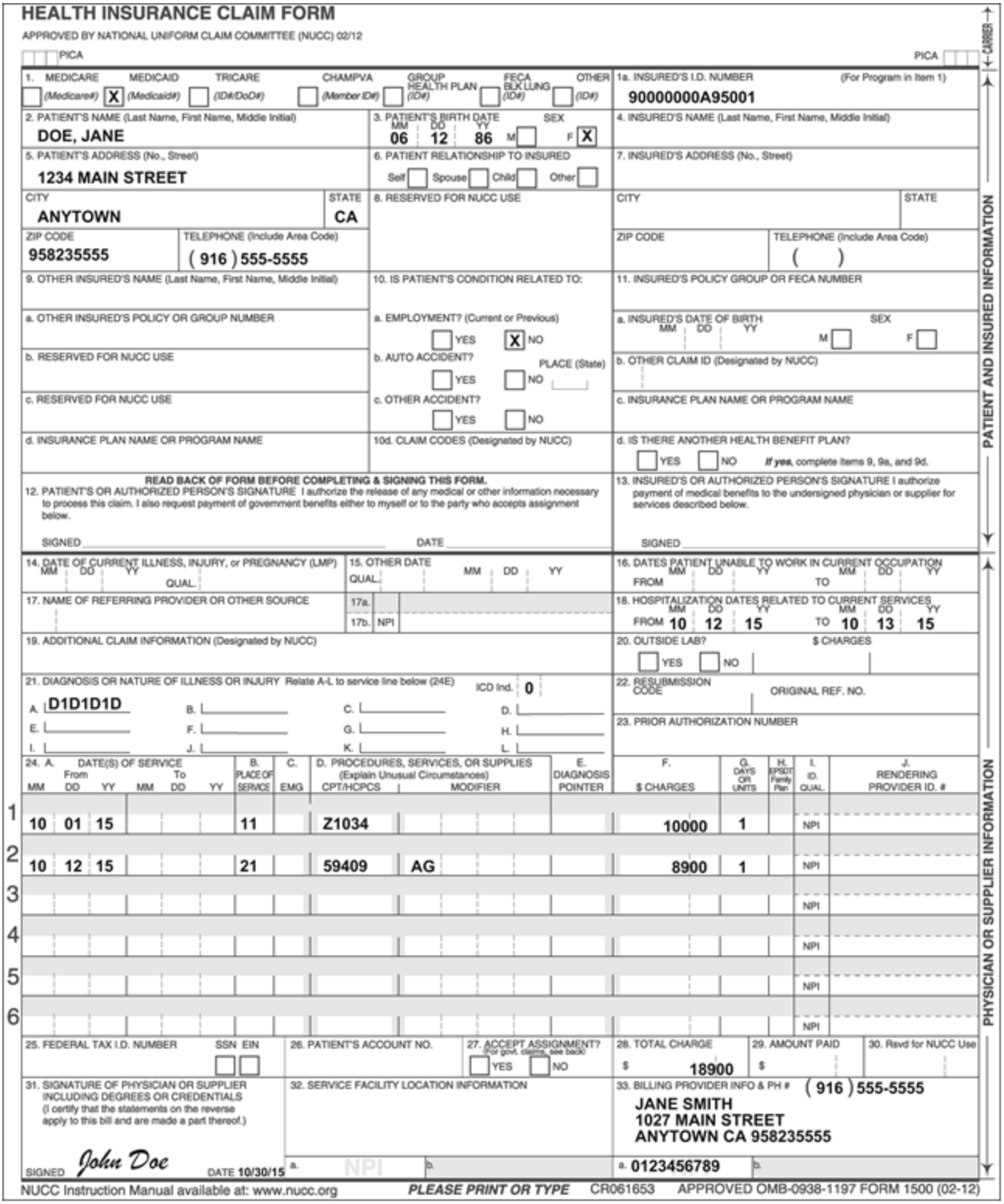
HCPCS code Z1034 (per-visit antepartum office visit) and CPT® code 59409 (per-visit vaginal delivery) with AG modifier (indicating the provider is the primary surgeon) are entered in the *Procedures, Services, or Supplies* field (Box 24D).

An appropriate ICD-10-CM diagnosis 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.

In the *Date(s) of Service* field (Box 24A), the date of the office visit, October 1, 2015 is entered on claim line 1 as 100115. The October 12, 2015 date of the vaginal delivery (CPT code 59409) is entered on claim line 2 as 101215. Enter Place of Service codes for each claim line in Box 24B. In this case, “11” (office) for the antepartum visit and “21” (inpatient hospital) for the delivery.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both Z1034 and 59409.

Note: Delivery services performed in an inpatient setting must be billed on a *CMS-1500*. The physician’s billing information is entered in the *Billing Provider Information and Phone #* field (Box 33). The physician’s NPI is entered in Box 33A.



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) 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, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 86 SEX M [ ] F [X]

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

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 12 15 TO 10 13 15

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

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		Z1034			10000	1		NPI	
2	10	12	15			21		59409	AG		8900	1		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 $ 18900

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 John 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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Figure 1: Per-Visit Billing of a Vaginal Delivery and Antepartum Office Visit.

Multiple Births: Claims for Twins A and B Using Mom's Medi-Cal ID Number

Figures 2 and 3. Multiple Births: Claims for Twin A and Twin B Using Mom's Medi-Cal ID Number.

A mother, who is admitted to the hospital on October 1, 2015 delivers twins the same day. The preceding claim (*Figure 1*) shows how to bill for the mother's vaginal delivery on a per-visit basis. The next two examples show how to bill normal newborn care services for the healthy twins. (When billing for care of multiple newborns, complete Boxes 1A, 2, 3, 4 and 6.)

Enter the mother's Medi-Cal ID Number as it appears on the Benefits Identification Card (BIC) in the *Insured's ID Number* field (Box 1A). (Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.)

Enter the babies' names in the *Patient's Name* field (Box 2). If the infants have not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl." Each baby from a multiple birth must also be designated by a number or letter (example: Jones Baby Girl Twin A).

Enter the infant's sex and date of birth in the *Patient's Birth Date/Sex* field (Box 3). Enter the mother's name in Box 4 (*Insured's Name*). Check the *Child* box in Box 6 (*Patient's Relationship to Insured*).

To facilitate payment of the claim, enter the words "Newborn Using Mother's ID Twin A (or B)" in the *Additional Claim Information* field (Box 19). Providers may also wish to use the *Patient's Account Number* field (Box 26) to enter Twin A (or B). This is not a required field, but it is for provider convenience. This field is repeated in all payment information (such as the *Remittance Advice Details* [RAD]), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.

An appropriate ICD-10-CM diagnosis 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.

In the *Date(s) of Service* field (Box 24A), enter the date that the newborn care service was rendered. October 1, 2015 is entered on claim line 1 as 100115. Enter the Place of Service code in Box 24B. In this case code "21" represents inpatient hospital.

Claim for Twin A:

Enter CPT code 99460 (initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant) in the *Procedures, Services or Supplies* field (Box 24D). Normal newborn care is billed with code 99460 for the **first** day of care. CPT code 99462 (subsequent hospital care, for the evaluation and management of a normal newborn) is billed on separate claim lines, as shown.

Claim for Twin B:

‹‹The claim for twin B is billed the same as for twin A, no modifier is needed to indicate this is a separate beneficiary.››

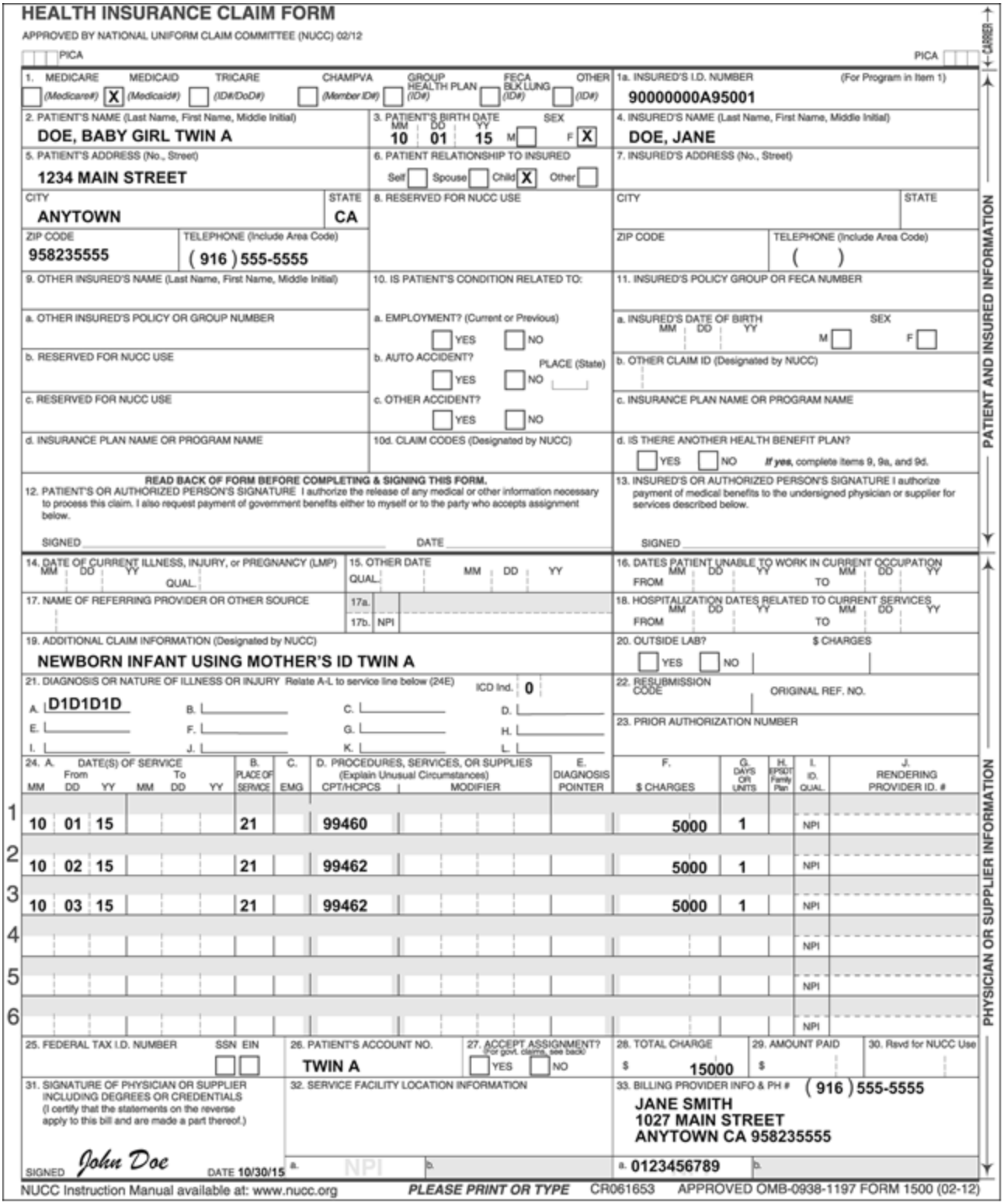
Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both codes 99460 and 99462.

In this case, the same doctor who delivers the babies also examines both twins. Therefore, the same NPI used for the mother (in this case 0123456789) is entered in the *Billing Provider Info & Phone #* field (Box 33).

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.

Other Physician Examines Infants

In many cases, a physician other than the delivering physician examines the newborn(s). In such instances, the name, address, telephone number and NPI of the physician who examines the infants is entered in Box 33 and 33A.



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) 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, BABY GIRL TWIN A

3. PATIENT'S BIRTH DATE MM DD YY: 10 01 15 SEX M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] 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 [ ]

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): NEWBORN INFANT USING MOTHER'S ID TWIN A

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

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			21		99460			5000	1		NPI	
2	10	02	15			21		99462			5000	1		NPI	
3	10	03	15			21		99462			5000	1		NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: TWIN A

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 John 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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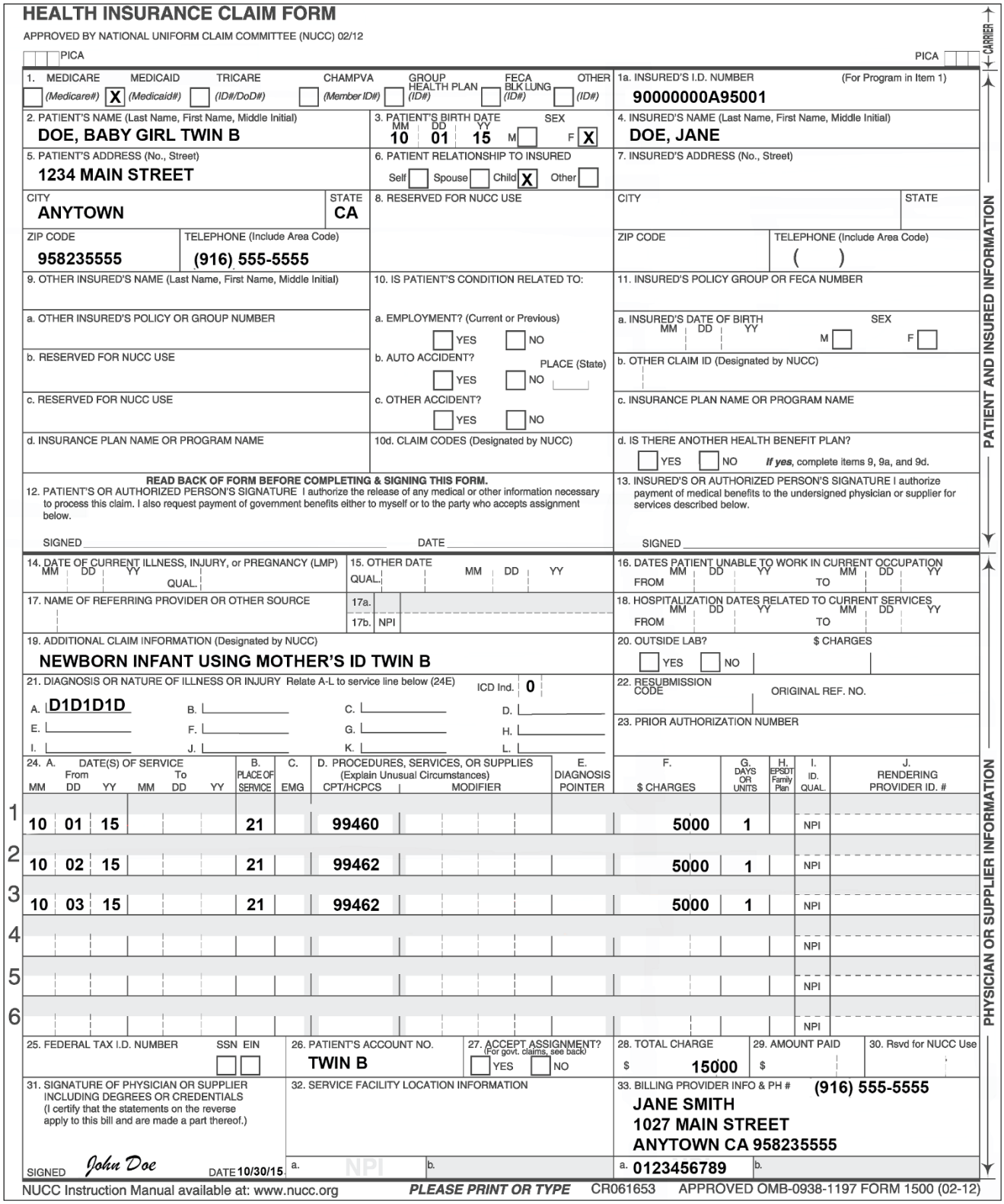
Figure 2: Multiple Births: Claim for Twin A Using Mom's Medi-Cal ID Number



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | 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, BABY GIRL TWIN B

3. PATIENT'S BIRTH DATE MM DD YY: 10 01 15 SEX M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [X] 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

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): NEWBORN INFANT USING MOTHER'S ID TWIN B

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:

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			21		99460			5000	1		NPI	
2	10	02	15			21		99462			5000	1		NPI	
3	10	03	15			21		99462			5000	1		NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN:

26. PATIENT'S ACCOUNT NO.: TWIN B

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 John 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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3: Multiple Births: Claim for Twin B Using Mom's Medi-Cal ID Number.

Per-Visit Billing of C-Section and Postpartum Office Visit

Figure 4. Per-Visit Billing of Cesarean Section Delivery and Postpartum Office Visit.

CPT code 59514 (per-visit cesarean section delivery) with AG modifier (indicating the provider is the primary surgeon) and HCPCS code Z1038 (per-visit postpartum visit) are entered in the *Procedures, Services or Supplies* field (Box 24D).

In this example, appropriate ICD-10-CM codes are entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21) for primary and secondary diagnoses.

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.

In the *Date(s) of Service* field (Box 24A), the date of the cesarean section, October 1, 2015, is entered on claim line 1 as 100115. The date of service for the postpartum office visit, October 20, 2015 is entered on claim line 2 as 102015. Enter Place of Service codes “21” (inpatient hospital) and “11” (office) on the appropriate claim lines in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both 59514 and Z1038.

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

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				21		59514	AG		48064	1		NPI	
2	10	20	15				11		Z1038			5340	1		NPI	
3															NPI	
4															NPI	

I OR SUPPLIER INFORMATION

Figure 4: Per-Visit Billing of Cesarean Section Delivery and Postpartum Office Visit.

Per-Visit Billing of Antepartum Office Visit and Ultrasound

Figure 5. Per-Visit Billing of Antepartum Office Visit and Ultrasound.

HCPCS code Z1034 for per-visit antepartum visit and SB modifier (indicating service was rendered by a Nurse Midwife) are entered in the *Procedures, Services or Supplies* field (Box 24D). Also entered in this field, on the next claim line, is CPT code 76805 for ultrasound service without a modifier, indicating the provider is submitting a claim for both the technical and professional components of the ultrasound service.

In this example, an ICD-10-CM diagnosis code is included 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.

In the *Date(s) of Service* field (Box 24A), the date of the office visit, October 1, 2015, is entered on claim line 1 as 100115. The October 4, 2015 date for ultrasound is entered on claim line 2 as 100415. Both the procedures were performed in an office so “11” (office) is placed in Box 24B for both claim lines.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both Z1034 and 76805.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) LINE 1: CNM MARTHA LOWE LIC 523450
LINE 2: SEE ATTACH. FOR ULTRASOUND JUSTIF.

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

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		Z1034	SB		10000	1		NPI	
2	10	04	15			11		76805			20000	1		NPI	
3														NPI	
4														NPI	

I OR SUPPLIER INFORMATION

Figure 5: Per-Visit Billing of Antepartum Office Visit and Ultrasound.

Internal Fetal Monitor Billed With Modifier 99

Figure 6. Internal Fetal Monitor Billed With Modifier 99.

CPT code 59051 (fetal monitoring during labor by consulting physician with written report; interpretation only) with required modifier 99 are entered in the *Procedures, Services or Supplies* field (Box 24D). Code 59051 is reimbursable only with modifier 99, which, in this case, requires that the words “Independent Procedure” be included in the *Additional Claim Information* field (Box 19). Also required in this field is the date of delivery.

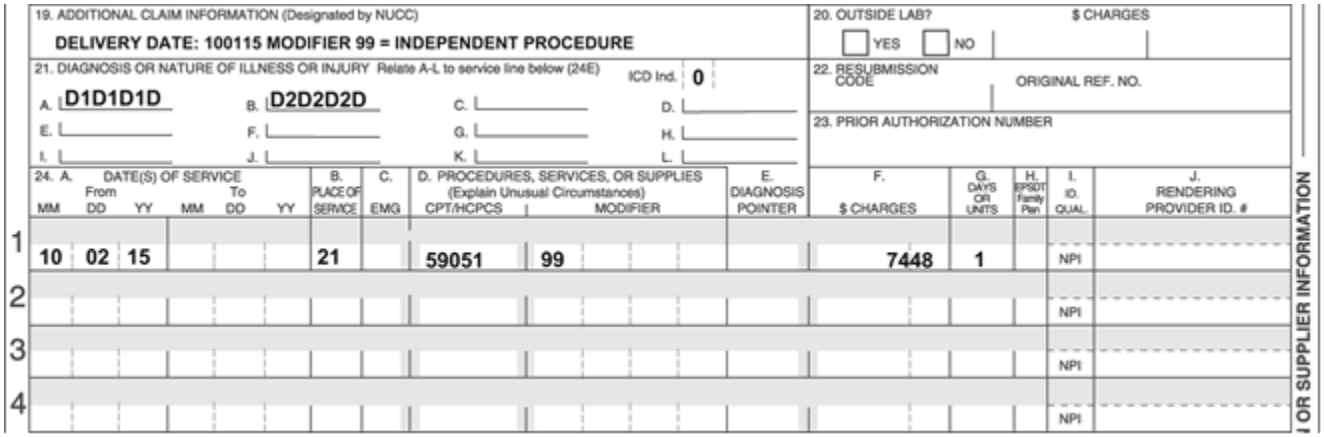
In this example, appropriate ICD-10-CM codes are entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21) for primary and secondary diagnoses.

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.

In the *Date(s) of Service* field (Box 24A), enter the date of service in the six-digit format. Enter Place of Service code “21” (inpatient hospital) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the Days or Units field (Box 24G) for 59051.

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



19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
DELIVERY DATE: 100115 MODIFIER 99 = INDEPENDENT PROCEDURE

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	02	15			21		59051	99		7448	1		NPI	
2														NPI	
3														NPI	
4														NPI	

I OR SUPPLIER INFORMATION

Figure 6: Internal Fetal Monitor Billed With Modifier 99.

Billing for Routine Obstetric Care with Cesarean Delivery and Intraoperative Tubal Ligation

Figure 7. Billing of Routine Obstetric Care Including Antepartum Care, Cesarean Delivery and Postpartum Care in Conjunction with Intraoperative Tubal Ligation.

CPT code 59510 (routine obstetric care including antepartum care, cesarean delivery, and postpartum care) with AG modifier (indicating the provider is the primary surgeon) and code 58611 (tubal ligation) with modifier 51 (in this case, special circumstance) are entered in the *Procedures, Services or Supplies* field (Box 24D).

The C-section service rendered in connection with this claim is being billed globally and therefore the claim must be billed in the "from-through" format. The "from" date of service for code 59510 is the first date the recipient was seen for the pregnancy. In this case, October 1, 2015 is entered as "100115" on claim line 1 as the "from" date. The "through" or "to" date of service (June 30, 2016), which is the date of the delivery, is entered in the "through" column as "063016". Because the tubal ligation service was performed with the C-Section delivery, the same date (June 30, 2016) is entered in the "From" and "To" columns of the *Date(s) of Service* field (Box 24A) for code 58611.

Enter the date of the Last Menstrual Period (LMP) in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14).

Physicians must use:

- Modifier AG (primary physician) to bill for the C-section or intra-abdominal surgery
- Modifier 51 to bill the tubal ligation (CPT code 58611)
- A sterilization *Consent Form* (PM 330)

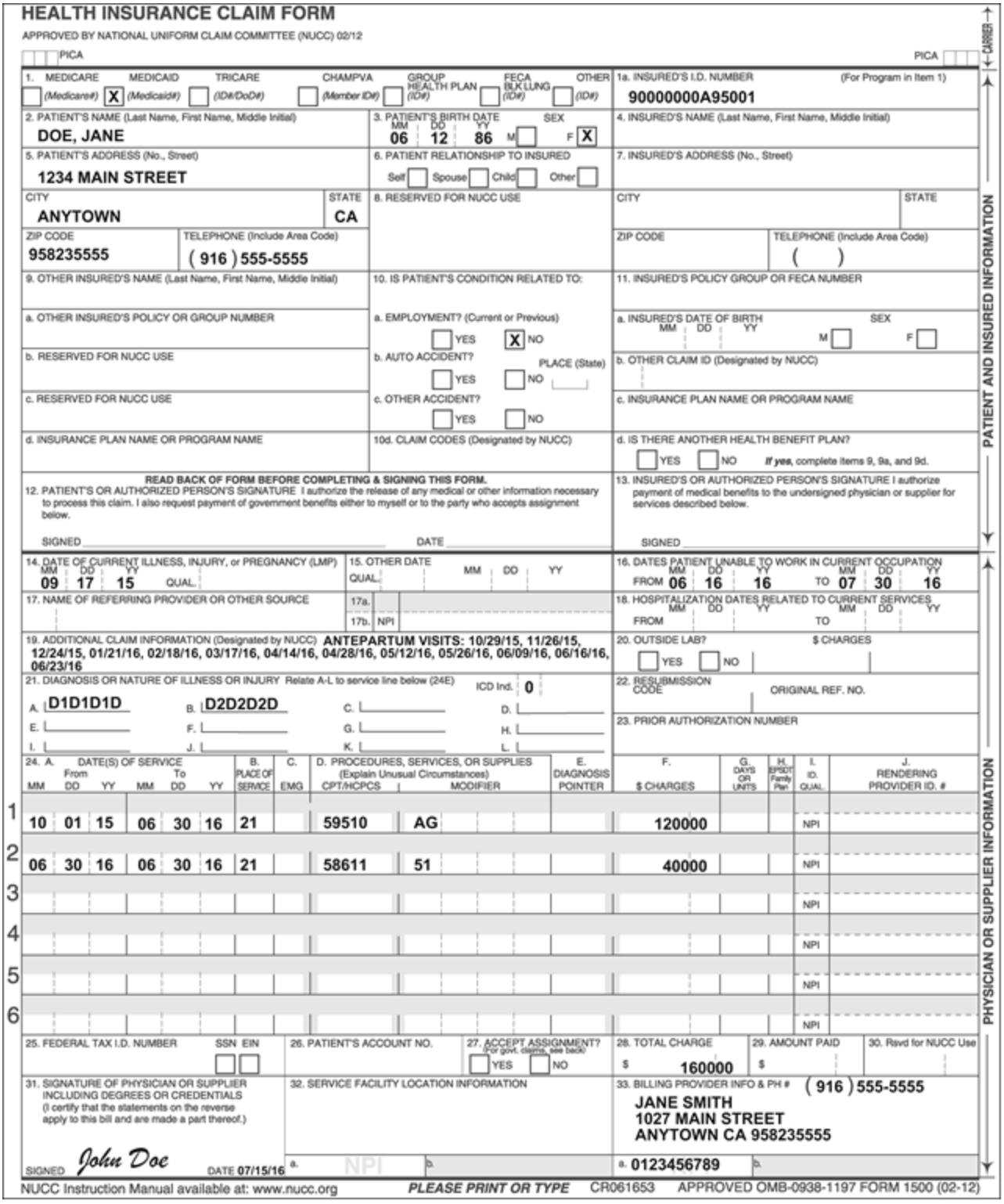
In order to bill globally, the dates of the thirteen antepartum visits must be entered in the *Additional Claim Information* field (Box 19).

In *Figure 7*, on the following page, appropriate ICD-10-CM codes are entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21) for primary and secondary diagnoses.

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.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both 59510 and 58611.

Note: Assistant Surgeons must bill CPT code 59514 with modifier 80 and code 58611 with modifier 99. The *Additional Claim Information* field (Box 19) of the *CMS-1500* must note that modifier 99 was used to signify "modifier 80 and modifier 51." Delivery services performed in an inpatient setting must be billed on a CMS-1500 claim using the physician's NPI. The NPI is entered in Box 33A.



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) 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, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 86 SEX M [ ] F [X]

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? PLACE (State) YES [ ] NO [ ]

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: 09 17 15 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 06 16 16 TO 07 30 16

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ANTEPARTUM VISITS: 10/29/15, 11/26/15, 12/24/15, 01/21/16, 02/18/16, 03/17/16, 04/14/16, 04/28/16, 05/12/16, 05/26/16, 06/09/16, 06/16/16, 06/23/16

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	06 30 16	21		59510	AG		120000			NPI	
2 06 30 16	06 30 16	21		58611	51		40000			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 $ 160000

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 John Doe DATE 07/15/16

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)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 7: Billing of Routine Obstetric Care Including Antepartum Care, Cesarean Delivery and Postpartum Care in Conjunction with Intraoperative Tubal Ligation.

‹‹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.