Incontinence Medical Supplies Example: CMS-1500

Page updated: April 2022

The example in this section is to assist providers in billing for incontinence medical supplies on the *CMS-1500* claim form. Refer to the *Incontinence Medical Supplies: An Overview* 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 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.

Incontinence Supplies

Figure 1. Incontinence supplies.

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

In this example, a DME company is billing for contracted incontinence supplies. Incontinence supplies are restricted for use in chronic pathologic conditions causing incontinence.

‹‹The referring prescriber's name and NPI are entered in the *Name of Referring Provider or Other Source* field (Box 17) and the *NPI* field (Box 17B) because the recipient's prescriber must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that patient.››

Documentation proving that the recipient is not eligible for Medicare is attached and "See Attachment" is entered in the *Additional Claim Information* field (Box 19).

The primary and secondary ICD-10-CM codes are entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21) to reflect the condition causing the incontinence and the type of incontinence.

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.

The recipient in this case is over 65 years of age and is not eligible for Medicare; therefore, a "6" is entered in the *Resubmission Code* field (Box 22). Because the supplies are being delivered to the patient's home, "12" is entered in the *Place of Service* field (Box 24B).

HCPCS code T4522 (adult size brief) is entered in the *Procedures, Services or Supplies* field (Box 24D). Claims for contracted medical supplies require a qualifier/UPN in the shaded area of Box 24A. Enter the unit of measure/numeric quantity in the shaded area of Box 24D.

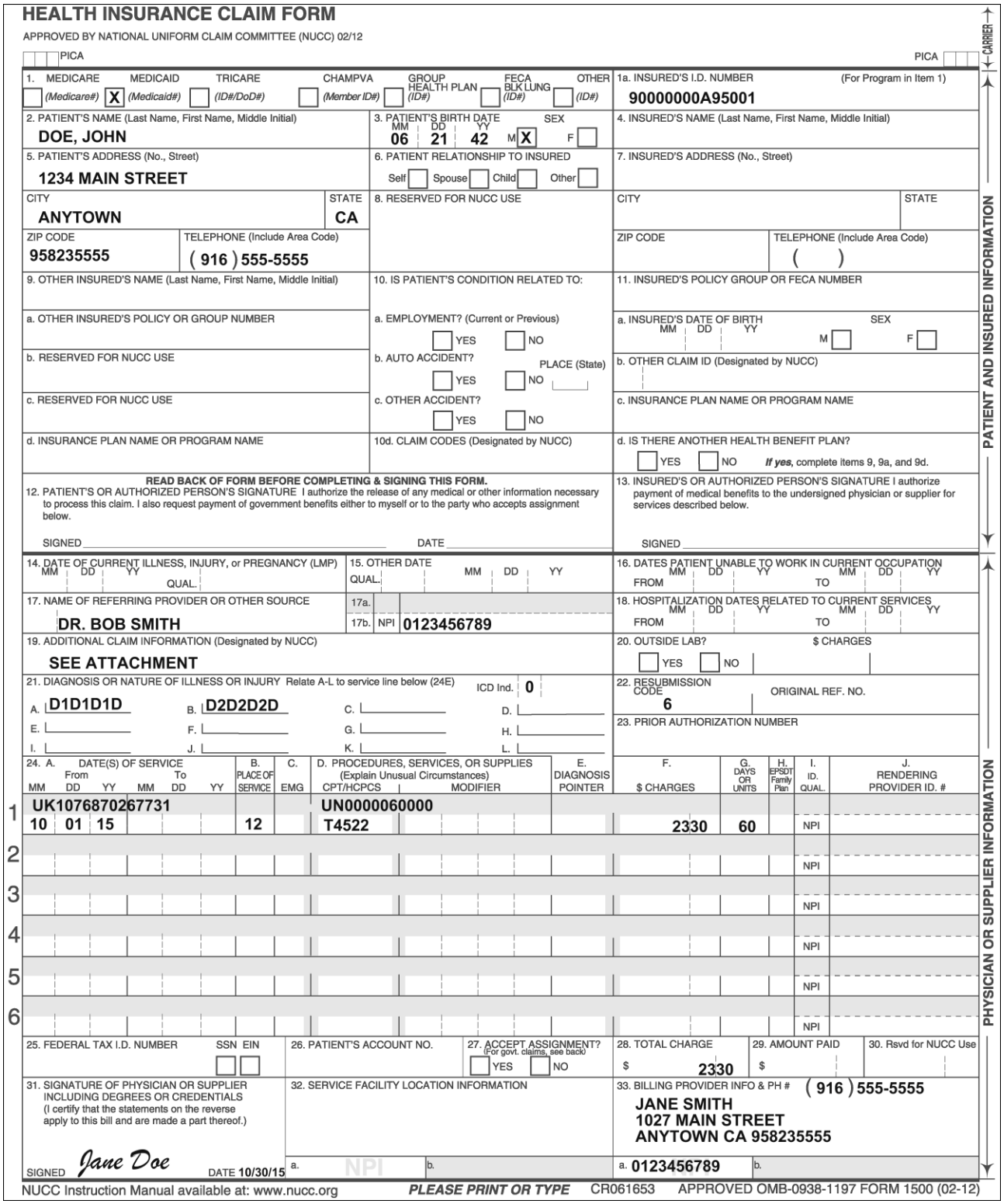
These numbers are based on the product dispensed to the recipient. See the appropriate *Incontinence Products* section for a listing of UPNs and UPN qualifiers by manufacturer. Also see the *CMS-1500 Completion* section for more details about both the qualifier/UPN and the unit of measure/quantity.

Note: Unit of measure and numeric quantity are optional. Absence of these two elements will not result in claim denial.

Note: Claims for non-contracted medical supplies with a listed price do not require a qualifier/UPN or an attachment (invoice, manufacturer's catalog page or price list. (Non-contracted supplies without a listed price do require documentation of product cost as an attachment (invoice, manufacturer's catalog page or price list) to the claim.

Enter the usual and customary charges in the *Charges* field (Box 24F) and the number "60" in the *Days or Units* field (Box 24G) to indicate that a quantity of 60 briefs is being billed.

Figure 1. **Incontinence Supplies**



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, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 42 | 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)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

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

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

c. OTHER ACCIDENT? YES [ ] NO [ ]

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

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

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

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: DR. BOB SMITH

17a.

17b. NPI 0123456789

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): SEE ATTACHMENT

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: 6 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 UK1076870267731 10 01 15		12		UN0000060000 T4522			2330	60		NPI	
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 $ 2330

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

‹‹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.