CMS 1500
Billing Instructions

Division of Medical Assistance Programs
August 2007

Contents

Introduction **1**

Claims processing **2**

CMS 1500 claim form **3**

Valid claim formats 3

CMS 1500 Health Insurance Claim Form (revised 8/05) 4

Required fields 5

Helpful tips 9

Appendix **12**

Third Party Resource (TPR) explanation codes 14

Single insurance coverage 14

Multiple insurance coverage 15

Supplemental information 16

Supplemental information examples 17

Introduction

The *CMS 1500 Billing Instructions* handbook is designed to help those who bill the Department's Division of Medical Assistance Programs (DMAP) for Medicaid services complete the billing form correctly the first time. This will give you step-by-step instructions so that DMAP can pay you, the provider, more quickly. Use this handbook with the General Rules and your provider guidelines (administrative rules and supplemental information), which contain information on policy and covered services specific to your provider type.

This handbook lists the requirements for completion prior to sending your claim to DMAP for payment processing, as well as helpful hints on how to avoid common billing errors.

The *CMS 1500 Billing Instructions* are designed to assist the following providers:*

- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetists
- Chemical Dependency
- Chiropractors
- Doctors of Medicine
- Durable Medical Equipment
- Family Planning Clinics
- Federally Qualified Health Centers
- Home Enteral/Parenteral IV
- Independent Laboratories
- Medical Transportation
- Mental Health
- Naturopaths
- Nurse Practitioners
- Occupational Therapy
- Opthalmologists
- Optometrists
- Physical Therapy
- Podiatrists
- Portable X-Ray Providers
- Psychologists
- Public Health Departments
- Rural Health Clinics
- School-Based Health Services

*This list does not include all provider types that use the CMS 1500. If in doubt of which claim form to use, contact DMAP Provider Services at 800-336-6016 for assistance, or refer to your provider guidelines.

Claims processing

The federal government requires DMAP to process Medicaid claims through an automated claim processing system known as MMIS - the Medicaid Management Information System. This system is a combination of people and computers working together to process claims.

Paper claims submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an Internal Control Number (ICN). The scanner converts 2,500 to 3,000 documents per hour into images.
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as client name, prime identification number, the date of service, and provider number.
- Finally, the data and images are stored on an Electronic Document Management System (EDMS) which staff access via the DHS intranet.

Once the claim is scanned through the Optical Character Reader, staff can immediately access submitted claim information by checking certain MMIS screens. The system processes most paper claims within 30 days. The fewer questions the computer asks, the more quickly it can process the claim.

The system performs daily edits for presence and validity of data. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs, and the system produces checks for claims that successfully pass all edits and audits.

DMAP staff members will see the claim only if MMIS cannot make a payment decision based on the information submitted. The system directs the claim to DMAP staff for specific medical or administrative review. This type of claim is a *suspense (suspended) claim.*

DMAP does not return denied claims to providers. Instead, DMAP mails a listing of all claims paid and/or denied to the provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

CMS 1500 claim form

DMAP does not supply this form. This federal form is available through local business forms suppliers, the Oregon Medical Association, or by calling the U.S. Government Printing Office at 202-512-1800.

Valid claim formats

DMAP only accepts the 8/05 version of the CMS 1500 claim form. We will return claims submitted on the 12/90 form with a request to resubmit the claim on the correct form.

DMAP processes hardcopy claims using Optical Character Recognition (OCR) scanning. Make sure your claim forms meet OCR specifications. If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

CMS 1500 Health Insurance Claim Form (revised 8/05)

Shaded boxes are fields DMAP uses to process your claim; your claim may suspend or deny if information in this box is missing or incomplete.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — 1a

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — 2

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

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

CITY — STATE

8. PATIENT STATUS — Single Married Other

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

Employed — Full-Time Student — Part-Time Student

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

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) — 21

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID 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	24A	24B		24D	24E	24F	24G		NPI	24J
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 $ — 28

29. AMOUNT PAID $

30. BALANCE DUE $ — 30

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 ____ DATE ____

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

33. BILLING PROVIDER INFO & PH # ( ) — 33 — a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Required fields

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Box	Field	Description
1 a	**Insured ID Number**	**Use the eight (8)-digit Medicaid Prime Identification Number.** The 0prime number is printed on the Medical Care Identification, or you can obtain it through the Automated Information System Plus (AIS Plus) at 800-522-2508.
2	**Patient's Name**	**Enter the client name exactly as it is printed on the Medical Care Identification.** DO NOT use "nicknames".
9	**Other Insured's Name**	**If the client has other medical coverage, enter the appropriate two (2)-digit third party resource (TPR) explanation code.** This code explains both insurance actions. See *Appendix* for TPR explanation codes.
10	**Is Patient's Condition Related To:**	Check the appropriate box when an injury is involved.
17	**Name of Referring Physician or Other Resource**	**Enter the name of the referring provider.** If the client has a Primary Care Manager (PCM), enter the PCM's name in this box.
17 a	**ID Number of Referring Physician**	**Enter the six (6)-digit DMAP provider number of the referring provider.** • If the referring provider is not enrolled with DMAP, enter six (6) nines (999999). • If the client has a Primary Care Manager (PCM), enter the PCM's six (6)-digit DMAP provider number in this box.
17 b	**NPI of Referring Physician**	**Enter the PCM or referring physician's 10-digit National Provider Identifier (NPI).**

Box	Field	Description
21	**Diagnosis or Nature of Injury**	**Enter the primary diagnosis/condition of the client by entering current ICD-9-CM codes.** The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records. • Enter up to four (4) codes in priority order. Carry out codes to their highest degree of specificity. • DO NOT enter the decimal point. *Note*: This box indicates 1,2,3,4. List diagnosis codes in that order. See Box 24 E. *Exceptions:* Transportation providers and Lifeline providers **do not** need to provide diagnosis information.
23	**Prior Authorization Number**	**If the service was prior authorized, enter the nine (9)-digit Prior Authorization number that DHS issued for the service.** DO NOT bill prior-authorized and non-authorized services on the same claim form. You must submit separate CMS 1500 claim forms.
24	**Supplemental information**	**In the shaded area across Fields 24A through 24H, enter supplemental information about the service rendered.** Enter the appropriate qualifier(s), followed by the information. • If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. • See *Appendix* for more information about entering supplemental information.
24 A	**Dates of Service**	**This box must list numeric dates of service.** If you use "From – To" dates, a service must be on consecutive days and provided no more than once per day. As example: Correct........05-01-07 thru 05-05-07........5 units Incorrect......05-01-07 thru 05-06-07........5 units

Box	Field	Description
24 B	Place of Service	**List the two (2)-digit Place of Service (POS) code for where the service was provided.** Use the standard CMS codes available in your CPT or HCPCS book.
24C	Emergency Flag	If the service was provided in an emergency situation, enter a "Y" in this box.
24 D	Procedures, Services, or Supplies	**List the five (5)-digit procedure code for the service provided.** Use only CPT or HCPCS codes. Add up to two (2) national modifiers.
24 E	Diagnosis Code	**Only list one (1) number that cross-references the diagnosis as listed in Box 21.** DO NOT enter the actual ICD-9-CM code here. *Exceptions:* Transportation providers and Lifeline providers **do not** need to provide diagnosis information.
24 F	$ Charges	**Enter the total usual and customary charge for each line item.** DMAP will not calculate your charge if billing for more than 1 item (unit).
24 G	Days or Units	**This number must match the number of days being provided as indicated in Box 24A.** As example: Procedure code 97110 (therapeutic exercise), 1 unit = 15 minutes, you treated the patient for 45 minutes, the number of units you must record is 3, not 1. The units must match the number of consecutive days.
24 H	EPSDT Family Planning	Enter a Y in this Box only if the services are related to Family Planning or Early Periodic Screening Diagnosis Treatment (EPSDT).
24 J	Rendering Provider ID	**List the six (6)-digit DMAP "performing" provider number.** When clinics or group practices bill DMAP using their specific billing provider number in Box 33, they must complete this field to indicate who performed the service being billed. *Exceptions:* Transportation providers **do not** need to complete this field.
26	Patient's Account No.	If a patient account number is provided in this box, DMAP will print it on the Remittance Advice (RA).

Box	Field	Description
28	**Total Charge**	**Enter the total amount for all charges listed in Box 24F.** All lines listed under Box 24F should add up to the total amount billed.
29	**Amount Paid**	**Enter the total amount paid by any prior resource(s).** These DO NOT include: • DMAP co-payments. • Previous payment amounts made by DMAP. • Contract write-offs required by other payers.
30	**Balance Due**	**Enter the total balance due.** Box 28 minus Box 29 equals Box 30, "balance due".
33	**Physician's, Supplier's Billing Name, Address**	**If you have an NPI, enter the ten (10)-digit number in part "a" of this field. In part "b" of this field, enter your six (6)-digit DMAP billing or performing provider number.** DMAP will pay this provider.

Helpful tips

Additional information is available on DMAP's Web site at www.oregon.gov/DHS/healthplan. Click on "Tools for Providers," then "Billing Tips."

READ your provider guidelines! Pay special attention to the billing instructions. Be sure you have the most current rulebook and supplemental information that are in effect for the date of service you are billing for.

- Provider guidelines are available at DMAP's Web site. Click on "Tools for Providers," then "Policies." Click "more" for a list of current guideline pages.
- If you do not have internet access, you may contact DMAP at 800-527-5772 and ask to have provider guidelines mailed to you.

VERIFY client eligibility on the date of service. The date of service is that date you provided the service. If possible, photocopy the Medical Care ID and/or verify with one of the electronic eligibility verification services listed on DMAP's Electronic Eligibility Verification Web page at www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

- Automated Information System (AIS) by phone: Call 800-522-2508;
- AIS Plus on the Web: Go to the Electronic Eligibility Verification Web page, then click "AIS" to register for Web-based access;
- Electronic Eligibility Verification Service (EEVS) vendor: Go to the Electronic Eligibility Web page, or call 800-336-6016 for a copy of the vendor list.

The client name and number on the CMS 1500 must match the name and number shown on the client's Medical Care Identification (ID). A Medical Care ID number is always eight characters and shows in Box 6 of the Medical Care ID. The General Rules supplemental information book shows an example of a Medical Care ID.

BEFORE billing DMAP…

- **MAKE SURE** that you billed prior resources and reported the correct dollar amount in Box 29.
- **DO NOT** attach prior resource EOBs.
- **ALWAYS USE** the correct 2-digit third party resource (TPR) explanation code in Box 9 when the client has TPR. If the client has TPR, you must enter

the appropriate code even when the TPR made no payment. Always enter a code if the client has more than one TPR available.

USE commercially available "red form" versions of the CMS 1500 (not black and white copies) whenever possible. When you submit your claims on "red forms," Optical Character Recognition (OCR) technology scans the claim data directly into the claims processing system. OCR technology increases the accuracy and efficiency of claims processing, but cannot be used on black and white claim forms.

USE only one prior authorization number in Box 23. DO NOT bill authorized services and services that do not require authorization on the same claim form. However, all surgical procedures (prior authorized and non-prior-authorized) must be billed on the same form.

USE the correct combination of procedure code and modifier appropriate for the service billed under your provider type. DMAP will determine the Type of Service (TOS) based on the provider ID number, procedure code, and modifier, as applicable, that you submit to us on your claim.

- If you do not enter this information correctly, our system may assign your claim the wrong type of service, which may cause the system to incorrectly pay or deny the claim. If it denies the claim, the paper RA may indicate a denial due to TOS error.
- Refer to your provider guidelines to determine which modifier corresponds with your procedure code that is reported in Box 24D.

ALWAYS ENTER the DMAP 6-digit provider number you want DMAP to send payment to in Box 33. It is crucial that you list this information. An invalid or missing provider number could delay your payment, make payment to a wrong provider or deny your payment.

- If the performing provider is different from the billing provider, enter the performing provider number in Box 24J.
- A "performing" provider is the individual who provided the service; a "billing" provider bills on behalf of the performing provider.

CHECK your claim form for legibility so that we can clearly read it. Avoid tiny print, print that overlaps onto a line, entering more than 6 lines per claim, and poorly hand written claim forms. Complete only the required boxes.

EACH CMS 1500 is a complete billing document. If there is not enough space available on the CMS 1500 to bill all procedures provided **on the same date of service**, complete a new billing form for the rest of the procedures. Remember to bill all surgical procedures (prior authorized and non-prior-authorized) on the same form. **DO NOT** carry over totals from one CMS 1500 to the other.

READ the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, and if you should re-bill or submit an Individual Adjustment Request form (DMAP 1036).

CONTACT Provider Services at 800-336-6016 for assistance in completing your CMS 1500 or other questions regarding a medical claim.

Appendix

Third Party Resource (TPR) explanation codes

Use in Box 9 on the CMS 1500.

Single insurance coverage

Use a single insurance code when the client has only one insurance policy in addition to Medicaid.

Code	Description
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Canceled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Patient
RP	Requested Information Not Received by Insurance from Policyholder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance Mandated Under Administrative/Court Order Through an Absent Parent-and Not Paid Within 30 Days
OT	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Multiple insurance coverage

Use in Box 9 of CMS 1500. Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid.

MP	Primary Insurance Paid – Secondary Paid
SU	Primary Insurance Paid – Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid – Secondary Service Not Covered
SC	Primary Insurance Paid – Secondary Patient Not Covered
ST	Primary Insurance Paid – Secondary Canceled/Terminated
SL	Primary Insurance Paid – Secondary Lapsed or Not in Effect
SP	Primary Insurance Paid – Secondary Payment Went to Patient
SH	Primary Insurance Paid – Secondary Payment Went to Policyholder
SA	Primary Insurance Paid – Secondary Denied - Service Not Authorized
SE	Primary Insurance Paid – Secondary Denied - Service Not Considered Emergency
SF	Primary Insurance Paid – Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Insurance Paid – Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Supplemental information

In the shaded areas across fields 24A through 24H on the CMS 1500 claim form, you can enter supplemental information about the service(s) rendered.

DMAP accepts the following types of supplemental information, accompanied by the appropriate qualifier:

Qualifier	Information Type
7	Anesthesia duration in hours and/or minutes with start and end times
ZZ	Narrative description of unspecified codes
N4	National Drug Codes (NDC). In addition, use the following qualifiers when reporting NDC units: • F2 – International Unit • GR – Gram • ML – Milliliter • UN - Unit
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC)
CTR	Contract rate

Supplemental information examples

The following examples show how to enter different types of supplemental information as listed above. They are not meant to provide direction on how to code for specific services.

Anesthesia Services – Payment based on 15-minute units

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
7Begin 1245 End 1415 Time 90 Minutes															123456
06	01	07	06	01	07	1		00770	P2	1	### ##	6		NPI	1234567890

Anesthesia Services – Payment based on minutes as units

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
7Begin 1245 End 1415															123456
06	01	07	06	01	07	1		00770	P2	1	### ##	90		NPI	1234567890

Unspecified Code

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
ZZ Kaye Walker															123456
06	01	07	06	01	07	4		E1399		1	### ##	1		NPI	1234567890

NDC Code

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
N400026064871 Immune Globulin Intravenous UN2															123456
06	01	07	06	01	07	1		J1563		1	### ##	20		NPI	1234567890

Vendor Product Number

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
VPA122BIC5D6E7G															123456
06	01	07	06	01	07	1		A6410		1	##	##		NPI	1234567890

Global Trade Item Number

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
OZ00301134678906															123456
06	01	07	06	01	07	1		A6410		1	## ##	1		NPI	1234567890