Medical Transportation - Ground: Billing Examples

Page updated: June 2023

Examples in this section are to assist providers in billing for ground medical transportation on the *CMS-1500* claim form. Refer to the *Medical Transportation – Ground* 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.

Non-Emergency Transport

Figure 1. Non-Emergency Transport.

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

In this example, a medical transport company is billing for a non-emergency trip from the patient's home to a dialysis clinic and back. HCPCS codes A0130 (non-emergency transportation: wheelchair van) and A0380 (BLS mileage [per mile] [use for wheelchair and litter van transports only]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because HCPCS code A0380 is billed on a per mile basis, the total mileage is entered in the *Days or Units* field (Box 24G). A "2" is entered in the *Days or Units* field (Box 24G) for HCPCS code A0130 to indicate that the transport was round trip, to and from the dialysis clinic.

Also in this example, a referring physician's name is entered in the *Name of Referring Provider or Other Source* field (Box 17) and NPI in Box 17B because a written prescription from the patient's physician is required for the non-emergency transport to and from the dialysis clinic.

Also note that an approved *Treatment Authorization Request* (TAR) is required for non-emergency transportation. The TAR number is entered in the *Prior Authorization Number* field (Box 23).

A description of the trip is shown in the *Additional Claim Information* field (Box 19) of the claim indicating the times the patient was picked up for each trip. Because mileage is billed, the complete origination and destination addresses, including cities and ZIP codes, are required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim. "Modifier "76" (repeat procedure or service by same physician or other qualified health care professional) may be appended to each billing code. Without this information, subsequent trips for the same recipient on the same DOS may be denied as duplicate service.

Enter the usual and customary charges in the Charges field (Box 24F).

Figure 1. Non-Emergency Transport.

HEALTH INSURANCE CLAIM FORM					
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)	02/12			PICA	
	HAMPVA GROUP	FECA OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)	
	HAMPVA GROUP HEALTH PLAN (ID#)	FECA OTHER BLK LUNG (ID#)	90000000A95001	(For Fogram mem 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DA	TE SEX	4. INSURED'S NAME (Last Name	e, First Name, Middle Initial)	
DOE, JOHN	06 21 62	2 MX F			
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONS		7. INSURED'S ADDRESS (No., S	Street)	
1234 MAIN STREET	STATE 8. RESERVED FOR NUC	Child Other	CITY	STATE	
	CA	00 03E	CITY	SIAIE	
ZIP CODE TELEPHONE (Include Area Code))		ZIP CODE	TELEPHONE (Include Area Code)	
958235555 (916) 555-5555				()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	10. IS PATIENT'S COND	ITION RELATED TO:	11. INSURED'S POLICY GROUP	OR FECA NUMBER	
- OTHER INCHES IN POLICY OF COOLIN ALLIMPED	- FAIDLOVALENTO (O	ant as Bassiana)			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Curr		a. INSURED'S DATE OF BIRTH	SEX F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	X NO	b. OTHER CLAIM ID (Designated	d by NUCC)	
	YES	PLACE (State)		,,	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OF	TELEPHONE (Include Area Code) () O OR FECA NUMBER SEX M F d by NUCC) R PROGRAM NAME H BENEFIT PLAN?	
	YES	NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Des	signated by NUCC)	d. IS THERE ANOTHER HEALTH	H BENEFIT PLAN?	
READ BACK OF FORM BEFORE COMP	ETINO & CIONINO TUIO FORM			If yes, complete items 9, 9a, and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I autho	rize the release of any medical or otl		payment of medical benefits t	D PERSON'S SIGNATURE I authorize o the undersigned physician or supplier for	
to process this claim. I also request payment of government benefit below.	s either to mysell or to the party who	accepts assignment	services described below.		
SIGNED	DATE		SIGNED		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMF	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
QUAL.	QUAL.	DD YY	FROM	то	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		18. HOSPITALIZATION DATES F	RELATED TO CURRENT SERVICES MM DD YY	
DR. BOB SMITH 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	17b. NPI 012345678	9	FROM 20. OUTSIDE LAB?	TO \$ CHARGES	
RESPONSE TO CALL/ROUND TRIP TRANS ON THE SAME DAY C CA 95831 TO ANYTOWN DIALYSIS CLINIC 401 JAY ST., ANYTOW					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L	to conside line below (24E)	D Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.	
A. L B. L	c. L	D			
E. L F. L	G. L	н. 🗀	23. PRIOR AUTHORIZATION NU	JMBER	
I.	K. LPROCEDURES, SERVICES, OR S	L. L. E.	01234567891 F. G.	H. I. J.	
From To PLACE OF	(Explain Unusual Circumstances)	DIAGNOSIS	DAYS OR	H. J. J.	
	PT/HCPCS MODIFIE	ER POINTER	\$ CHARGES UNITS	H. I. B. P.	
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2 01 01 22 41 4					
01 01 22 41 A	0380		18 00 12	NPI	
	1 ! !	! 1	1 ! 1		
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6				NPI	
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	2345	CCEPT ASSIGNMENT? or govt. claims, see back)	\$ 58 i 60 \$	1 1 1	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERV	ICE FACILITY LOCATION INFOR			PH# (916) 555-5555	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse			NON-EMERGENC	` . , .	
apply to this bill and are made a part thereof.)			14555 HILLSIDE A		
			ANYTOWN CA 958	3235555	
SIGNED DATE a.	NPI b.		a. 1234567890 b.		
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRI	NT OR TYPE CR	061653 APPROVED C	MB-0938-1197 FORM 1500 (02-12)	

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Emergency Transport

Figure 2. Emergency Transport.

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

In this example, a medical transport company is billing for emergency transportation from the patient's home to an acute care hospital. HCPCS codes A0429 (Ambulance service, basic life support, emergency transport [BLS-emergency]), A0422 (Ambulance [ALS or BLS] oxygen and oxygen supplies, life sustaining situation) and A0425 (ground mileage, per statute mile [use for ambulance transports only]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because emergency services are being billed, an "X" is entered in the *EMG* field (Box 24C).

All emergency medical transportation requires both:

- The emergency service indicator on the claim (EMG field [Box 24C] on the CMS-1500 claim form, or condition code 81 [emergency indicator] in boxes 18 thru 24 on the UB-04 claim form).
- A statement in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form, or *Remarks* field (Box 80) on the *UB-04* claim form, or on an attachment, supporting that an emergency existed. The statement may be made by the provider of transportation and must include:
 - The nature of the emergency
 - The name of the hospital to which a recipient was transported
 - No acronym in place of a hospital name (for example, VMC). Abbreviations are acceptable (for example, Valley Med. Ctr.)
 - The name of the physician (Doctor of Medicine [M.D.] or Doctor of Osteopathic Medicine [D.O.]) accepting responsibility for the recipient. The name of the staff M.D., D.O. or emergency department medical director is acceptable.

Note: A physician's signature is not required

When billing a night call charge, code A0427 (Ambulance service, advanced life support, emergency transport, level 1 [ALS1-emergency]) or code A0429, depending on whether the services provided are advanced life support (ALS) or basic life support (BLS), is billed with modifier UJ (services provided at night). The time the service was rendered must be entered in the *Additional Claim Information* field (Box 19) or on an attachment.

Because mileage is billed, the complete origination and destination addresses, including city and ZIP code, are required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim.

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Figure 2. Emergency Transport.

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		
PICA		PICA
1. MEDICARE MEDICAID TRICARE CHAMPI	A GROUP FECA OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) X (Medicaid#) (ID#/DoD#) (Member	— HEALTH PLAN — BLK LUNG — I	9000000A95001
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN	3. PATIENT'S BIRTH DATE SEX MM DD YY 06 21 62 MX F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1234 MAIN STREET	Self Spouse Child Other	
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ANYTOWN CA		
ZIP CODE TELEPHONE (Include Area Code) (916) 555-5555		ZIP CODE TELEPHONE (Include Area Code) () 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) C. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
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 X NO	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	1	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		
READ BACK OF FORM BEFORE COMPLETIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either	release of any medical or other information necessary	YES NO If yes, complete items 9, 9a, and 9d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
below. SIGNED	DATE	SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15.	OTHER DATE AL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM DD TO TO TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) EMERG. AMBUL FROM HOME DUE TO UNRESPONSIVE PATIENT AT 12:55 AM, 509 OA ST. ANYTOWN, CA 98331. DR. DENISE SMITH IS M.D. RESPONSIBLE.		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to ser		22. RESUBMISSION ORIGINAL REF. NO.
A. L B. C. L E. L G. L	D. L	23. PRIOR AUTHORIZATION NUMBER
I.	L. L. EDURES, SERVICES, OR SUPPLIES E.	F. G. H. I. J.
From To PLACE OF (Expl	ain Unusual Circumstances) DIAGNOSIS	F. G. H. I. J. DAYS BESDIT ID. RENDERING OR Femily Pen QUAL. PROVIDER ID. #
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10 01 16 41 X A0422		F. G. H. I. J.
10 01 16 41 X A042		53 25 15 NPI
1		NPI
5		NPI NPI
		INPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S 1234	(For govt. claims, see back)	28. TOTAL CHARGE
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.)	CILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (916) 555-5555 MIDTOWN AMBULANCE 345 ELM ANYTOWN CA 958235555
SIGNED Jane Doe DATE 10/31/16 a. N	DI FASE PRINT OR TYPE CRO	a. 0123456789 b. DARLOSS-1197 FORM 1500 (02-12)

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Non-Medical Transportation

Figure 3. Non-Medical Transportation.

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

In this example, a medical transport company is billing for a trip from the patient's home to a medical clinic and back. Note this patient does not require non-emergency medical transportation by ambulance, wheelchair or litter van. HCPCS codes A0120 (non-emergency transportation: mini-bus, mountain area transports, or other transportation systems) and A0390 (ALS mileage [per mile]) are entered in the *Procedures, Services or Supplies* field (Box 24D). Because HCPCS code A0390 is billed on a per mile basis, the total mileage is entered in the *Days or Units* field (Box 24G). A "2" is entered in the *Days or Units* field (Box 24G) for HCPCS code A0120 to indicate that the transport was round trip, to and from the medical clinic.

A description of the trip is shown in the *Additional Claim Information* field (Box 19) of the claim indicating the times the patient was picked up for each trip. Because mileage is billed, the complete origination and destination addresses, including cities and ZIP codes, are required in the *Additional Claim Information* field (Box 19) or on an attachment to the claim.

«If multiple trips are provided for the same recipient on the same date of service, enter the time of day and the points of destination in the *Additional Claim Information* field (Box 19) of the *CMS-1500 claims*. Modifier "76" (repeat procedure or service by same physician or other qualified health care professional) may be appended to each billing code on the claims accordingly. Without this information, subsequent trips for the same recipient on the same DOS may be denied as duplicate service.»

Enter the usual and customary charges in the *Charges* field (Box 24F).

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Figure 3. Non-Medical Transport.

HEALTH INSURANCE CI										
APPROVED BY NATIONAL UNIFORM CLAIM		02/12								
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		mber ID#)	GROUP HEALTH (ID#)	PLAN FECA BLK LUN (ID#)	IG (ID#)	90000000A9			(10171	ogram in nem 1/
2. PATIENT'S NAME (Last Name, First Name,					SEX	4. INSURED'S NAME		o Eiret Na	no Middle Ini	tial\
DOE, JOHN	, Milodie II III al)		ATIENT'S BII			4. INCOMED CHAME	(Last Hall	ie, i liai ivai	ne, made m	ueuj
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1234 MAIN STREET			Self Spo		Other	7.1100.1200710011		00000		
CITY	er		<u> </u>	OR NUCC USE	Other	CITY				STATE
ANYTOWN	-	CA	ESERVED	OR NOCC USE						SIAIE
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	,					Zii GGDL		1)	raca code,
(0.0)) 555-555	40.1	O DATIENTI	OCHDITION DEL	TED TO	44 INDUDEDIO DOLLA	27.000	1)	
9. OTHER INSURED'S NAME (Last Name, Fir	rst Name, Middle Initial)	10.1	SPAHENIS	S CONDITION RELA	TED TO:	11. INSURED'S POLK	JY GHOU	POHFECE	NUMBER	
- OTHER INCURENCE DOLLOW OR OPOUR	NUMBER .	—	MINI OVALEN	T2 /0		INCLUDED DATE	a= alaz:			n=14
a. OTHER INSURED'S POLICY OR GROUP N	NUMBER	a. E	MPLOTMEN	T? (Current or Previ		a, INSURED'S DATE MM DD	i AA OE BIRTH			SEX
b. RESERVED FOR NUCC USE		—.	LITO ACCID!	YES NC	,				М	F
D. RESERVED FOR NUCC USE		b. A	UTO ACCIDE		PLACE (State)	b. OTHER CLAIM ID	Designate	d by NUCC)	
				YES NO	·					
c. RESERVED FOR NUCC USE		c. O	THER ACCIE			c. INSURANCE PLAN	NAME OF	RPROGRA	M NAME	
			L	YES NO						
d. INSURANCE PLAN NAME OR PROGRAM	NAME	10d.	CLAIM COD	DES (Designated by	NUCC)	d. IS THERE ANOTH	R HEALT	H BENEFIT	PLAN?	
						YES	NO	If yes, com	plete items 9,	, 9a, and 9d.
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to process this claim. I also request payment						payment of medica services described		to the unde	isigned physic	Jaul or supplier for
below.										
SIGNED			DATE			SIGNED				
14. DATE OF CURRENT ILLNESS, INJURY, o	or PREGNANCY (LMP)	15. OTHE	R DATE	MM . DD	YY	16. DATES PATIENT	UNABLE J	g work i	N CUŖŖĘNT	ОССИРАТІОЙ
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		17b. NPI	i			FROM	1	'	TO	11
19. ADDITIONAL CLAIM INFORMATION (Des	signated by NUCC)					20. OUTSIDE LAB?			\$ CHARGES	
RESPONSE TO CALL/ROUND TRIP TRANS. ON 1 95831 TO ANYTOWN MEDICAL CLINIC 431 JAY 5	THE SAME DAY OF SERV ST., ANYTOWN, CA 9583	/. FROM PAT. 1 (10:15) & RI	. HOME AT 12: ETURN TRIP	34 MAIN STREET, AN TO PAT. HOME (13:45	YTOWN, CA)	YES	NO			
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E F		G. L		υ. <u></u>		23. PRIOR AUTHORI	ZATION N	UMBER		
I J,		K. L		H. L						
24. A. DATE(S) OF SERVICE		N								
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MM DD YY MM DD YY 10 01 19	PLACE OF SERVICE EMG CPT 99 A((Explain Uni T/HCPCS 0120	usual Circum	stances)	DIAGNOSIS	\$ CHARGES 35 30	2	Pien QU). AL. P	RENDERING
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MM DD YY MM DD YY 10 01 19 10 01 19 25. FEDERAL TAX I.D. NUMBER SSN 31. SIGNATURE OF PHYSICIAN OR SUPPLI INCLUDING DEGREES OR CREDENTIAL (I cortify that the statements on the reverse	PIACE OF SERVICE EMG CPT 99 A(99 A(10 A	(Explain UnitriHCPCS) 0120 0390 NT'S ACCOL 2345	76 Total Circum	stances) MODIFIER 27. ACCEPT AS (For govt. claim YES	DIAGNOSIS POINTER SIGNMENT? SIGNMENT?	\$ CHARGES 35 30 15 60 28. TOTAL CHARGE \$ 50	90 SER INFO 8	NE N	PAID 3	RENDERING PROVIDER ID. #
MM DD YY MM DD YY 10 01 19 10 01 19 25. FEDERAL TAX I.D. NUMBER SSN 31. SIGNATURE OF PHYSICIAN OR SUPPLII INCLUDING DEGREES OR CREDENTIAL	PIACE OF SERVICE EMG CPT 99 A(99 A(10 A	(Explain UnitriHCPCS) 0120 0390 NT'S ACCOL 2345	76 Total Circum	stances) MODIFIER 27. ACCEPT AS (For govt. claim YES	DIAGNOSIS POINTER SIGNMENT? SIGNMENT?	\$ CHARGES 35 30 15 60 28. TOTAL CHARGE \$ 50 33. BILLING PROVIDE	90 SER INFO &	NE N	PAID 3	RENDERING PROVIDER ID. #
MM DD YY MM DD YY 10 01 19 10 01 19 25. FEDERAL TAX I.D. NUMBER SSN 31. SIGNATURE OF PHYSICIAN OR SUPPLI INCLUDING DEGREES OR CREDENTIAL (I certify that the statements on the reverse apply to this bill and are made a part there	PIACE OF SERVICE EMG CPT 99 A(99 A(10 A	(Explain UnitriHCPCS) 0120 0390 NT'S ACCOL 2345	76 Total Circum	stances) MODIFIER 27. ACCEPT AS (For govt. claim YES	DIAGNOSIS POINTER SIGNMENT? SIGNMENT?	\$ CHARGES 35 30 15 60 28. TOTAL CHARGE \$ 50 33. BILLING PROVIDINON-MEDIC.	2 12 90 3 SER INFO 8 AL TRIDE AL	NE N	PAID 3 916) 55 ORT	RENDERING PROVIDER ID. #
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«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.