

**Sample Hospital Billing
Medicare/Managed Medicare
Hospital Outpatient Setting**

**PET/CT base of skull to mid-thigh Study
Monitoring Therapy R-CHOP: Case 1**

APPROVED OMB NO. 0938-0279

Any Hospital One Hospital Road Any City, Any State 00010		3 PATIENT CONTROL NO. XXXXXXXXXX		4 TYPE OF BILL 131	
5 FED. TAX NO. 66-66678		6 STATEMENT COVERS PERIOD FROM 02/27/2008		7 COV.D. 02/20/2008	
12 PATIENT NAME Siegel, Bonnie		13 PATIENT ADDRESS 123 Any Street Any City Any State USA			
14 BIRTHDATE 01/17/1934		15 SEX F		17 DATE ADMISSION 222222	
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE SPAN	
39 CODE		40 VALUE CODES		41 CODE	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATES	
45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES	
48 NON-COVERED CHARGES		49			
0404		NOPR PET/CT Torso		78815 Q0	
02/27/2008		1		XXXX:XX	
0343		F-18 FDG per dose		A9552	
02/27/2008		1		XXX:XX	
51 PROVIDER NO.		52 REL. INFO.		53 ASG BEN	
54 PRIOR P. AYMENTS		55 EST. AMOUNT DUE		56	
1122431					
DUE FROM PATIENT					
59 P. REL.		60 CERT. - SSN - HIC. - ID NO.		61 GR. OUP NAME	
62 INSURANCE GR. OUP NO.					
Bonnie Siegel		123-45-6789		Medicare	
XXXXXXX					
67 PRIN. DIAG. CD.		68 CODE		69 CODE	
70 CODE		71 CODE		72 CODE	
73 CODE		74 CODE		75 CODE	
76 ADM. DIAG. CD.		77 E-CODE		78	
79 P.C.		80 PRINCIPAL PROCEDURE		81 OTHER PROCEDURE	
82 ATTENDING PHYS. ID		83 OTHER PHYS. ID		84 OTHER PHYS. ID	
85 PROVIDER REPRESENTATIVE		86 DATE			
X					

Form Locator 42:
Enter revenue codes.
0404 PET Procedures
0343 Diagnostic Radiopharmaceutical

Form Locator 44:
Enter CPT or HCPCS code for procedures and radiopharmaceuticals or drug.
78815 PET/CT Skull base to mid-thigh
A9552 F-18 FDG, diagnostic, per study dose, up to 45 millicuries

Form Locator 46:
Enter the number of units based on the CPT or HCPCS code description

Form Locator 67 & 68:
Enter ICD-9-CM code for principle diagnosis in FL 67.
202.80 Other Lymphomas (malignant): NOS
Enter NOPR Identifier in FL 68
V70.7 Exam of Participants in Clinical Trials

Sample Physician Billing
Medicare/Managed Medicare
Hospital Outpatient Setting

PET/CT base of skull to mid-thigh Study
Monitoring Therapy R-CHOP: Case 1

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Siegel, Bonnie					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Siegel, Bonnie				
3. PATIENT'S BIRTH DATE MM DD YY 01 17 1934 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					5. PATIENT'S ADDRESS (No., Street) 123 Any Street				
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 Any Street				
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>					8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
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 Signature On File					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 Signature On File				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE (NOTE some payers require this field blank for use with Q0 (Zero.))					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 202.80					23. PRIOR AUTHORIZATION NUMBER				
24. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY					24. PROCEDURE(S), SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				
24. PLACE OF SERVICE					24. DIAGNOSIS CODE				
24. TYPE OF SERVICE					24. CHARGES				
24. DAYS OF SERVICE					24. RESERVED FOR LOCAL USE				
24. UNIT PAID					24. BALANCE DUE				
24. NAME, ADDRESS, ZIP CODE					XXXXXXX				
SIGNED					DATE				
PIN#					GRP#				

Form Locator 21 & 24E:
 Enter ICD-9-CM code for principle diagnosis in FL 21.
 Enter the line number corresponding to the procedure in FL 24E
 202.80 Other Lymphomas (malignant): NOS

Form Locator 24G:
 Enter the number of units based on the CPT or HCPCS code description

Form Locator 24D & 19:
 Enter CPT or HCPCS code for procedures interpreted by the physician
 In the hospital outpatient setting
 78815 PET/CT skull base to mid-thigh
 26 modifier, Professional Component
 Q0 (Zero) modifier, Investigational clinical service provided in a clinical research study that is in an approved clinical research study
 FL 19 In order to facilitate coverage and payment list description as NOPR Patient
 (Note some contractors require this field remain blank, if you experience difficulty try leaving field blank.)

Sample Physician Office
Medicare/Managed Medicare

**PET/CT base of skull to mid-thigh Study
Monitoring Therapy R-CHOP: Case 1**

Non-Hospital Technical

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HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Siegel, Bonnie					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Siegel, Bonnie				
3. PATIENT'S BIRTH DATE MM DD YY 01 17 1934 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					5. PATIENT'S ADDRESS (No., Street) 123 Any Street				
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 Any Street				
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>					8. PATIENT STATUS CITY: Any City STATE: AS				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. INSURED'S DATE OF BIRTH MM DD YY 01 17 1934 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
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: Signature On File					14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE (NOTE some payers require this field blank for use with Q0 (Zero.))					20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 202.80				
24. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY					24. PROCEDURE(S), SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				
24. PLACE OF SERVICE					24. DIAGNOSIS CODE				
24. TYPE OF SERVICE					24. \$ CHARGES				
24. DAYS OF SERVICE					24. DAYS OF SERVICE				
24. FAMILY PLAN					24. EMG				
24. COB					24. RESERVED FOR LOCAL USE				
24. IT PAID					24. BALANCE DUE				
24. NAME, ADDRESS, ZIP CODE					XXXXXXX				
SIGNED					DATE				
PIN#					GRP#				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form Locator 21 & 24E:
Enter ICD-9-CM code for principle diagnosis in FL 21. Enter the line number corresponding to the procedure in FL 24E

202.80 Other Lymphomas (malignant): NOS

Form Locator 24G:
Enter the number of units based on the CPT or HCPCS code description

Form Locator 24D & 19:
Enter CPT or HCPCS code for technical procedures performed by the PET center.

78815 PET/CT skull base to mid-thigh
A9552 F-18 FDG per dose
TC modifier, Technical Component
Q0 (Zero) modifier, Investigational clinical service provided in a clinical research study that is in an approved clinical research study
FL 19 In order to facilitate coverage and payment list description as NOPR Patient
(Note some contractors require this field remain blank, if you experience difficulty try leaving field blank.)

**Sample Physician Office
Medicare/Managed Medicare
Non-Hospital Global**

**PET/CT base of skull to mid-thigh Study
Monitoring Therapy R-CHOP: Case 1**

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PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Siegel, Bonnie					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Siegel, Bonnie				
3. PATIENT'S BIRTH DATE MM DD YY 01 17 1934 M <input type="checkbox"/> F <input checked="" type="checkbox"/>					5. PATIENT'S ADDRESS (No., Street) 123 Any Street				
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 123 Any Street				
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>					8. PATIENT STATUS CITY: Any City STATE: AS				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.				
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: Signature On File DATE:					14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
17a. I.D. NUMBER OF REFERRING PHYSICIAN					17b. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				
19. RESERVED FOR LOCAL USE (NOTE some payers require this field blank for use with Q0 (Zero.))					20.280 Other Lymphomas (malignant): NOS				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					22. PRIOR AUTHORIZATION NUMBER				
24. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY					24. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				
24. DIAGNOSIS CODE					24. \$ CHARGES				
24. DAYS OR UNITS					24. RESERVED FOR LOCAL USE				
24. PAID					24. BALANCE DUE				
24. NAME, ADDRESS, ZIP CODE					XXXXXXX				

Form Locator 21 & 24E:
Enter ICD-9-CM code for principle diagnosis in FL 21.
Enter the line number corresponding to the procedure in FL 24E

202.80 Other Lymphomas (malignant): NOS

Form Locator 24G:
Enter the number of units based on the CPT or HCPCS code description

Form Locator 24D & 19:
Enter CPT or HCPCS code for technical procedures performed by the PET center.

78815 PET/CT skull base to mid-thigh
A9552 F-18 FDG per dose
NO modifier, Global (Professional & Technical)
Q0 (Zero) modifier, Investigational clinical service provided in a clinical research study that is in an approved clinical research study
FL 19 In order to facilitate coverage and payment list description as NOPR Patient
(Note some contractors require this field remain blank, if you experience difficulty try leaving field blank.)