BILLING EXAMPLES
CESAREAN SECTION AND EARLY ELECTIVE DELIVERY with LMP DATE and PROPER CODING

EXAMPLE: Cesarean Section: CORRECT Diagnosis and POPULATED with LMP Date

1. Box 14 **Populated** with Date and Qualifier (484 - Last Menstrual Period (LMP)
2. **CORRECT PRIMARY** Diagnosis
3. Billed with Cesarean Section CPT code

PROPER BILLING

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 Signature on File.

1. 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 26 2016 QUAL. 484 | 15. OTHER DATE QUAL. MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN | 17a. | 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 01 27 2017 TO 01 31 2017

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 20. OUTSIDE LAB? YES NO $ CHARGES

2. 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. O76 B. Z370 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. #
01 28 17		21		59514	UC 80	AB	2950 00	1		NPI	
										NPI	

3.

EXAMPLE: Cesarean Section: INCORRECT Diagnosis and POPULATED LMP Date

1. Box 14 **Populated** with Date and Qualifier (484 - Last Menstrual Period (LMP)
2. **Incorrect PRIMARY** Diagnosis
3. Billed with Cesarean Section CPT code

DENY: EQ – Diagnosis does not support code

1. 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 03 2016 QUAL. 484 | 15. OTHER DATE QUAL. MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 12 27 2016 TO 12 29 2016

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 20. OUTSIDE LAB? YES NO $ CHARGES

2. 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. O34211 B. Z370 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. #
12 27 16		21		59514	UB 80	AB	2950 00	1		NPI	
										NPI	

3.

BILLING EXAMPLES
CESAREAN SECTION AND EARLY ELECTIVE DELIVERY with LMP DATE and PROPER CODING

EXAMPLE: Cesarean Section: CORRECT Diagnosis and WITHOUT LMP Date

1. Box 14 **WITHOUT** Date and Qualifier (484 – Last Menstrual Period (LMP)
2. **CORRECT PRIMARY** Diagnosis
3. Billed with Cesarean Section CPT code

DENY: LP - Missing or Invalid Last Menstrual Period (LMP)

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 Signature on File.

1. → 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 FROM TO
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN
17a
17b NPI
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 07 29 2016 TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20 OUTSIDE LAB? YES NO $ CHARGES

2. → 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 0
A. O3421 B. O24420 C. O403XX0 D. Z3A39
E. Z370 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 CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
07 29 16		21		59514	UC AS	ABCD	692 00	1		NPI	
										NPI	

3. ↗ (points to CPT code)

EXAMPLE: Delivery - POPULATED LMP date

1. Box 14 **Populated** with Date and Qualifier (484 – Last Menstrual Period (LMP)
2. Billed with Vaginal CPT code and Modifier UC (Delivery at 39 weeks of gestation or later)

PROPER BILLING

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 Signature on File.

1. → 14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02 23 2017 QUAL 484
15 OTHER DATE QUAL MM DD YY
16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a
17b NPI
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 09 2017 TO 11 10 2017
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. O76 B. Z370 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 CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
11 09 17		21		59409	UC	AB	2000 00	1		NPI	
										NPI	

2. ↗ (points to CPT code and modifier)

BILLING EXAMPLES

CESAREAN SECTION AND EARLY ELECTIVE DELIVERY with LMP DATE and PROPER CODING

EXAMPLE: Delivery - WITHOUT LMP Date populated

1. Box 14 **WITHOUT** Date and Qualifier (484 – Last Menstrual Period (LMP)
2. **CORRECT PRIMARY** Diagnosis
3. Billed with Vaginal CPT code and Modifier UB (Medically necessary delivery prior to 39 weeks of gestation)

DENY: LP - Missing or Invalid Last Menstrual Period (LMP)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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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 Signature on File.

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 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 11 06 2017 TO

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. O4202 B. Z3A38 C. Z370 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. #
11 06 17		21		59400	UB	ABC	4400 00	1		NPI	
										NPI	