

Sample Hospital Technical Billing

Medicare / Managed Medicare

Hospital Outpatient Prospective Payment System (HOPPS) Setting



1 Any Hospital One Hospital Road Any City, Any State 00010		2		3a PAY CONT. # XXXXXXXXXX		4 TYPE OF BILL 131	
6 PATIENT NAME Smith, Stephen S.		9 PATIENT ADDRESS 123 Any Street Any City Any State					
10 BIRTHDATE 01/17/1934		11 SEX M		12 DATE		13 ADMISSION	
14 TYPE		15 SRC		16 DMR		17 STAT	
18		19		20		21	
22 OCCURRENCE CODE		23 OCCURRENCE DATE		24 OCCURRENCE CODE		25 OCCURRENCE DATE	
26		27		28		29	

Form Locator 18-28:

Enter the condition "30" *Qualifying Clinical Trials Non-research services provided to all patients, including managed care enrollees enrolled in a Qualified Clinical Trial.*

Managed Medicare (e.g., Medicare MA Plan)

Submit claim to MA Plan, NOT MAC. MA plans vary, however Typically require prior authorization and may dictate imaging site be part of their network, however out of network can be possible.

Form Locators 39-41:

Enter code D4 & Clinical Trials No. 04426539
If paper claim include CT, CT 04426539
if electronic submission do not include the CT

42 REV. CD		43 DESCRIPTION		44 HCPCS / ICD-10 / HOPS CODE		45 SERVICE DATE		46 SERVICE UNITS		47 TOTAL CHARGES		48 NET COVERED CHARGES		49	
0404		IDEAS PET, limited		78811 Q0		01/01/2021		1		XXXX.XX					
0343		F-18 Florbetaben, Per Study Dose		Q9983 Q0		01/01/2021		1		XXXX.XX					
		F-18 Flutemetamol, Per Study Dose		Q9982 Q0											
		F-18 Florbetapir, Per Study Dose		A9586 Q0											

Form Locator 42:

Enter revenue codes.

0404 PET Procedures

0343 Diagnostic Radiopharmaceutical

Form Locator 46:

Enter the number of units based on the CPT or HCPCS code description

Form Locator 44:

Enter CPT or HCPCS code for procedure, radiopharmaceutical and modifier (Choose only one procedure and HCPCS radiopharmaceutical code based on equipment PET or PET/CT and tracer administered.)

78811 PET limited or **78814** PET/CT limited

Q0 (zero) Investigational clinical service provided in a clinical research study in an approved clinical research study

Choose the radiopharmaceutical administered:

Q9983 Florbetaben F-18, diagnostic, per study dose, up to 8.1 millicuries

Q9982 Flutemetamol F-18, diagnostic, per study dose, up to 5 millicuries

A9586 Florbetapir F-18, diagnostic, per study dose, up to 10 millicuries

Form Locator 67 & 67 A-C:

Enter ICD-10-CM code for principal diagnosis in FL 67.
F03.90 Unspecified dementia w/o behavioral disturbance

Enter CED Identifier in FL 67 A-C in primary or secondary diagnosis position, may vary by MAC
Z006 Encounter for exam for normal comparison and control in clinical research program

58 INSURED'S NAME Smith, Stephen S.		59 INSURED'S UNIQUE ID 123-45-6789		61 GROUP NAME Medicare		62 INSURANCE GROUP NO. XXXXXXXXXX	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 ADMIT DX G3184		67 PATIENT REASON DX Z006		68		69	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 OTHER PROCEDURE CODE DATE		77 OTHER PROCEDURE CODE DATE	
78 OTHER PROCEDURE CODE DATE		79 OTHER PROCEDURE CODE DATE		79 OTHER PROCEDURE CODE DATE		79 OTHER PROCEDURE CODE DATE	
80 REMARKS		81 CC		82		83	
84		85		86		87	
88		89		90		91	
92		93		94		95	
96		97		98		99	

Medicare/Managed Medicare



Hospital Outpatient Prospective Payment System (HOPPS)

Setting

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/12

NEW
iDEAS
Imaging Dementia—Evidence
For Amyloid Scanning

CARRIER

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER <input checked="" type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (DoD #) <input type="checkbox"/> (Member ID #) <input type="checkbox"/> (ID #) <input type="checkbox"/> (ID #) <input type="checkbox"/> (ID #)		1a. INSURED'S ID NUMBER (For Program in Item 1) 123-45-6789	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Stephen S.		3. PATIENT'S BIRTH DATE 01 17 1934	
5. PATIENT'S ADDRESS (No., Street) 123 Any Street		6. PATIENT RELATIONSHIP TO INSURER Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	
CITY Any City		8. RESERVED FOR NUCC USE	
ZIP CODE 00010		TELEPHONE (Include Area Code) 555 5555555	
11. INSURED'S POLICY GROUP OR FECA NUMBER 9876543210			
a. INSURED'S DATE OF BIRTH 01 17 1934			
SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
b. OTHER CLAIM ID (Designated by NUCC)			
c. INSURANCE PLAN NAME OR PROGRAM NAME Medicare Or MA Plan			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
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 04 01 16		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK Dr. Neurologist		17a. 1G 9999999999 17b. NPI 8888888888	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CT04426539			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24E) A. G3184 B. Z006 C. D. ICD Ind. 0			
23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From To 04 01 21 04 01 16		B. PLACE OF SERVICE 21	
C. EMG 78811		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 26 Q0 KX	
E. DIAGNOSIS AB		F. CHARGES 200 00	
G. DAYS OF UNUSUAL CIRCUMSTANCES 1		H. EPSDT Family Plan NPI	
I. ID. QUAL. 9999999999		J. RENDERING PROVIDER ID. #	
25. PHYSICIAN OR SUPPLIER INFORMATION SIGNED Signature on File			
26. DATE OF SIGNATURE 04 01 16			
27. SIGNATURE OF PHYSICIAN OR SUPPLIER			
28. DATE OF SIGNATURE			
29. SIGNATURE OF PHYSICIAN OR SUPPLIER			
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99. SIGNATURE OF PHYSICIAN OR SUPPLIER			
100. DATE OF SIGNATURE			

PATIENT AND INSURED INFORM

PHYSICIAN OR SUPPLIER INFORMATION



Medicare/Managed Medicare

Non-Hospital Technical

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/12

NEW
iDEAS
Imaging Dementia—Evidence
For Amyloid Scanning

CARRIER

PICA		PICA	
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (DoD #) CHAMPVA <input type="checkbox"/> (Member ID #) GROUP HEALTH PLAN <input type="checkbox"/> (ID #) FECA <input type="checkbox"/> (ID #) OTHER <input type="checkbox"/>		1a. INSURED'S POLICY NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Stephen S.		3. PATIENT'S BIRTH DATE MM DD YY 01 17 1934 M <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"/>	
CITY Any City	STATE	8. RESERVED FOR NUCC USE	
ZIP CODE	TELEPHONE (Include Area Code)		
	00010 555 5555555		
9. Item No. 21 & 24E: Enter ICD-10-CM code for principal diagnosis in Item No. 21A. Enter CED identifier in Item No. 21B, check with payer for placement Enter ICD indicator 0 for ICD-10-CM Enter Dx Ref. letter(s) corresponding to the procedure in Item No. 24E F03.90 Unspecified dementia w/o behavioral disturbance Z006 Encounter for exam for normal comparison and control in clinical research program		11. INSURED'S POLICY GROUP OR FECA NUMBER 9876543210	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 04 01 16		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK Dr. Neurologist		18. Enter the number of units based on the CPT or HCPCS code description Charges are for sample only, PET site to set rates.	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUC) CT04426539		20. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Report A-L to services line below (24E)) A. G3184 B. Z006 C. L D. L		22. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE MM DD YY MM DD YY 04 05 21 04 05 21 11		25. CHARGES F. CHARGES G. DAYS OF UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. # 78814 TC Q0 AB 3000 00 1 NPI 9999999999 04 05 21 04 05 21 11 A9599 Q0 AB 3135 00 1 NPI 9999999999	
26. VIZAMYL (FLUTEMETAMOL), 5 MCI, IV, NDC 1715606701		27. VIZAMYL (FLUTEMETAMOL), 5 MCI, IV, NDC 1715606701	

Managed Medicare (e.g., Medicare MA Plan)

Submit claim to MA Plan, NOT MAC. MA plans vary, however Typically require prior authorization and may dictate imaging site be part of their network, however out of network can be possible.

Item No. 24G:

Enter the number of units based on the CPT or HCPCS code description

Charges are for sample only, PET site to set rates.

Item No. 24B:

Enter Place of Service number.
11- Physician office

Item No. 19:

Enter Clinical Trials Number **CT04426539** (Mandatory requirement effective Jan. 1, 2014) if filing paper claim Use CT in front of 8 digit number. If filing electronic eliminate the CT and only list 8 digit number.

Item No. 24D:

Enter CPT or HCPCS code for procedure, radiopharmaceutical and modifier

(Chose only one procedure and HCPCS radiopharmaceutical code based on equipment PET or PET/CT and tracer administered.)

78811 PET limited or **78814** PET/CT limited

TC modifier, Technical Component

Q0 (zero) Investigational clinical service provided in a clinical research study in an approved clinical research study

Radiopharmaceuticals are contractor priced, may require invoice or additional information in box 19, 24 or other, check individual payer policy.

CHECK MAC and DOS for appropriate code that the payer may accept for payment.

Q9983 Flortbetaben F-18, diagnostic, per study dose, up to 8.1 millicuries

Q9982 Flutemetamol F-18, diagnostic, per study dose, up to 5 millicuries

A9586 Flortbetapir F-18, diagnostic, per study dose, up to 10 millicuries

Notes:

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Medicare/Managed Medicare

Non-Hospital Technical

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/12

NEW
iDEAS
Imaging Dementia—Evidence
For Amyloid Scanning

PICA		PICA	
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (DoD #) CHAMPVA <input type="checkbox"/> (Member ID #) GROUP HEALTH PLAN <input type="checkbox"/> (ID #) FECA <input type="checkbox"/> (ID #) OTHER <input type="checkbox"/>		1a. INSURED'S POLICY NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Stephen S.		3. PATIENT'S BIRTH DATE MM DD YY 01 17 1934 M <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"/>	
CITY Any City	STATE	8. RESERVED FOR NUCC USE	
ZIP CODE	TELEPHONE (Include Area Code)		
00010	555 5555555		
9. Item No. 21 & 24E: Enter ICD-10-CM code for principal diagnosis in Item No. 21A. Enter CED identifier in Item No. 21B, check with payer for placement Enter ICD indicator 0 for ICD-10-CM Enter Dx Ref. letter(s) corresponding to the procedure in Item No. 24E F03.90 Unspecified dementia w/o behavioral disturbance Z006 Encounter for exam for normal comparison and control in clinical research program			
11. INSURED'S POLICY GROUP OR FECA NUMBER 9876543210		a. INSURED'S DATE OF BIRTH MM DD YY 01 17 1934 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Medicare Or MA Plan	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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.	
SIGNED Signature On File DATE 04 01 16		SIGNED Signature on File	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK Dr. Neurologist		17a. ICG 9999999999 17b. NPI 8888888888	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CT04426539		20. CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Report A-L to services line below (24E)) ICD Ind. 0		22. PRIOR AUTHORIZATION NUMBER	
A. G3184	B. Z006	23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE MM DD YY MM DD YY 04 04 21 04 04 21 81		C. PLIES	
D. DIAGNOSIS POINTER		F. CHARGES	
E. DAYS OF UNITS		H. EPSDT Family Plan	
I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1 04 04 21 04 04 21 81 78814 TC Q0 AB 3000 00 1 NPI 9999999999		2 04 04 21 04 04 21 81 A9599 Q0 AB 2968 00 1 NPI 9999999999	
3 NEURACEC (FLORBETABEN), 8 MCI, IV, NDC 5482800130			

Managed Medicare (e.g., Medicare MA Plan)

Submit claim to MA Plan, NOT MAC. MA plans vary, however Typically require prior authorization and may dictate imaging site be part of their network, however out of network can be possible.

Item No. 24G:

Enter the number of units based on the CPT or HCPCS code description

Charges are for sample only, PET site to set rates.

Item No. 24B:

Enter Place of Service number.
81- IDTF

Item No. 19:

Enter Clinical Trials Number **CT04426539** (Mandatory requirement effective Jan. 1, 2014) if filing paper claim Use CT in front of 8 digit number. If filing electronic eliminate the CT and only list 8 digit number.

Item No. 24D:

Enter CPT or HCPCS code for procedure, radiopharmaceutical and modifier

(Chose only one procedure and HCPCS radiopharmaceutical code based on equipment PET or PET/CT and tracer administered.)

78811 PET limited or **78814** PET/CT limited

TC modifier, Technical Component

Q0 (zero) Investigational clinical service provided in a clinical research study in an approved clinical research study

Radiopharmaceuticals are contractor priced, may require invoice or additional information in box 19, 24 or other, check individual payer policy.

Q9983 Florbetaben F-18, diagnostic, per study dose, up to 8.1 millicuries

Q9982 Flutemetamol F-18, diagnostic, per study dose, up to 5 millicuries

A9586 Florbetapir F-18, diagnostic, per study dose, up to 10 millicuries



Medicare/Managed Medicare

Non-Hospital Global

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/12

NEW
iDEAS
Imaging Dementia—Evidence
For Amyloid Scanning

PICA		PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (DoD #) <input type="checkbox"/> CHAMPVA (Member ID #) <input type="checkbox"/> GROUP HEALTH PLAN (ID #) <input type="checkbox"/> FECA BLK LUNG (ID #) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S POLICY NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Stephen S.		3. PATIENT'S BIRTH DATE MM DD YY 01 17 1934 M <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"/>	
CITY Any City	STATE	8. RESERVED FOR NUCC USE	
ZIP CODE	TELEPHONE (Include Area Code)		
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11. INSURED'S POLICY GROUP OR FECA NUMBER 9876543210		a. INSURED'S DATE OF BIRTH MM DD YY 01 17 1934 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME Medicare Or MA Plan	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>		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 04 01 16		SIGNED Signature on File	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK Dr. Neurologist		17a. 1G 9999999999 17b. NPI 8888888888	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) CT04426539		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Repeate A-L to services line below (24E)) A. G3184 B. Z006 C. I D. I E. I F. I G. I H. I I. I J. I	
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY 04 07 21 04 07 21		B. PLACE OF SERVICE 11	
C. ICD-10-CM CODE 78814		D. ICD-10-CM CODE Q0	
E. AB		F. CHARGES 3200 00	
G. DAYS OF SERVICE 1		H. EPSDT Family Plan NPI	
I. RENDERING PROVIDER ID. # 9999999999		J. RENDERING PROVIDER ID. # 9999999999	
2. 04 07 21 04 07 21 11 78814 Q0 AB 3200 00 1 NPI 9999999999		3. 04 07 21 04 07 21 11 A9586 Q0 AB 2756 00 1 NPI 9999999999	

Managed Medicare (e.g., Medicare MA Plan)

Submit claim to MA Plan, NOT MAC. MA plans vary, however Typically require prior authorization and may dictate imaging site be part of their network, however out of network can be possible.

Item No. 24G:

Enter the number of units based on the CPT or HCPCS code description

Charges are for sample only, PET site to set rates.

Item No. 24B:

Enter Place of Service number.
11- Physician office

Item No. 19:

Enter Clinical Trials Number **CT04426539** (Mandatory requirement effective Jan. 1, 2014) if filing paper claim Use CT in front of 8 digit number. If filing electronic eliminate the CT and only list 8 digit number.

Item No. 24D:

Enter CPT or HCPCS code for procedure, radiopharmaceutical and modifier

(Chose only one procedure and HCPCS radiopharmaceutical code based on equipment PET or PET/CT and tracer administered.)

78811 PET limited or **78814** PET/CT limited

No modifier, Global Billing includes Professional and Technical Component

Q0 (zero) Investigational clinical service provided in a clinical research study in an approved clinical research study

Radiopharmaceuticals are contractor priced, may require invoice or additional information in box 19, 24 or other, check individual payer policy.

Q9983 Flortbetaben F-18, diagnostic, per study dose, up to 8.1 millicuries

Q9982 Flutemetamol F-18, diagnostic, per study dose, up to 5 millicuries

A9586 Flortetapir F-18, diagnostic, per study dose, up to 10 millicuries

Notes:

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