

Superbill Creation Guide

Build a perfect superbill from scratch — step by step

A superbill is the most important document in medical billing. It is a detailed, itemized receipt that lists who the patient is, what the provider did, what diagnosis they have, and what it costs. Insurance companies and patients use superbills to process reimbursements. Think of it as the single source of truth for every claim you submit.

Why a Complete Superbill Matters

Faster Payment: Clean superbills produce clean claims. Clean claims are typically paid within 2 weeks.

Fewer Denials: Missing information is the number-one cause of claim denials. A complete superbill prevents most of them.

Patient Trust: Patients appreciate a clear, professional receipt that explains exactly what they are being charged for.

Audit Protection: A well-documented superbill protects your practice during insurance audits and compliance reviews.

The 10 Required Sections of a Superbill

1

Practice / Provider Information

Name of the practice, provider name, address, phone number, NPI (National Provider Identifier), and Tax ID (TIN). This tells the insurer exactly WHO is billing them.

■ *Tip: Include both the individual NPI and the group NPI if you bill under a group practice.*

2

Patient Information

Full legal name, date of birth, address, and phone number. This must match exactly what is on file with the insurance company — even a small spelling error can cause a denial.

■ *Tip: Verify patient demographics at every visit, not just for new patients.*

3

Insurance Information

Insurance plan name, policy/member ID, group number, and the name of the primary insured if different from the patient. For patients with two plans, list both primary and secondary.

■ *Tip: Photocopy the insurance card (front and back) at every single visit.*

4

Date of Service

The exact date(s) the service was provided. If care spans multiple days, list the start and end dates. This is critical — claims must be filed within the payer's timely filing window.

■ *Tip: Most payers require claims within 90–365 days of service. Know each payer's specific deadline.*

5

Referring Provider

If the patient was referred, include that provider's full name and NPI. Some plans (especially HMOs) require a valid referral number or the claim will be denied.

■ *Tip: Always confirm referral and authorization numbers before submitting the claim.*

6

Diagnosis Codes (ICD-10)

List the ICD-10 codes describing WHY the patient was seen. Use multiple codes when appropriate. The diagnosis must support the medical necessity of every procedure billed.

■ *Tip: Always use the most specific ICD-10 code available. Unspecified codes increase denial risk.*

7

Procedure Codes (CPT / HCPCS)

List every CPT or HCPCS code for services performed. Each code represents one specific action — an exam, a lab test, a procedure, an injection, etc.

■ *Tip: Include applicable modifiers (e.g., -25, -59) to prevent bundling denials.*

8

Fee (Billed Amount)

The provider's standard charge for each procedure. This is your full list price — NOT the expected payment. The insurer applies their contracted rate separately.

■ *Tip: Maintain a current fee schedule and charge the same amount to all payers for the same service.*

9

Provider Signature

The treating provider must sign or authenticate the superbill, certifying the information is accurate and that services were actually rendered.

■ *Tip: Electronic signatures are acceptable when your system creates a proper audit trail.*

10

Place of Service Code

A two-digit code showing where the service was performed. Common codes: 11 = Office, 21 = Inpatient Hospital, 22 = Outpatient Hospital, 23 = Emergency Room.

■ *Tip: The place of service affects reimbursement rates — always double-check its accuracy.*

Top 10 Superbill Mistakes — and How to Avoid Them

#	Common Mistake	How to Fix It
1	Wrong patient name or date of birth	Verify against the insurance card and government-issued ID at every visit.
2	Missing or incorrect NPI number	Check the NPI registry at nppes.cms.hhs.gov before submitting.
3	Vague or unspecified diagnosis codes	Use the most specific ICD-10 code. Avoid 'unspecified' when a better code exists.
4	Forgetting required modifiers	Modifier -25, -59, -50, and others are essential to prevent automatic bundling denials.
5	Wrong Place of Service code	Wrong POS changes your reimbursement rate. Double-check every time.
6	Missing referral or authorization number	HMO claims without a referral number are almost always automatically denied.
7	Filing past the timely filing deadline	Set up a tracking system to submit claims within every payer's specific deadline.
8	Duplicate claim submission	Track submitted claims to avoid re-submitting the same claim twice.
9	Incorrect unbundling of codes	Some CPT codes are bundled — you cannot bill them separately without a valid modifier.
10	Missing or unauthenticated provider signature	Unsigned superbills can be rejected during audits or medical record reviews.

Sample Superbill Template — Print and Use

PRACTICE INFORMATION	PATIENT INFORMATION
Practice Name: _____	Patient Name: _____
Provider Name: _____	Date of Birth: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
NPI #: _____	Insurance ID: _____
Tax ID: _____	Group #: _____

Date of Service	CPT Code	Mod	ICD-10 Code	Description	Fee
__/__/__	_____	__	_____	_____	\$ _____
__/__/__	_____	__	_____	_____	\$ _____
__/__/__	_____	__	_____	_____	\$ _____
__/__/__	_____	__	_____	_____	\$ _____
				TOTAL:	\$ _____

Provider Signature: _____

Date: _____