To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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1.0 Description of the Procedure, Product, or Service

Physician fluoride varnish services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations hereinafter specified. **Only the procedure codes listed in this policy are covered under the N.C. Medicaid Physician Fluoride Varnish Program**.

The Division of Health Benefits (DHB) has adopted procedure codes and descriptions as defined in the most recent edition of *Current Dental Terminology* (CDT 2015).

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing*

Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid covers a total of six oral screening packages (examination, preventive oral health and dietary counseling, and application of fluoride varnish) per beneficiary from the time of tooth eruption until the child is 3½ years of age. These services can be provided at well-child checkups, during a sick visit, or at a separately scheduled visit.

Example of Oral Screening Preventive Package Visits

Well-Child Visit (months)	Procedure Performed
6	Yes (if teeth are erupted)
9	Yes (if teeth are erupted)
12	Yes
18	Yes
24	Yes
36	Yes

Begin providing the services as soon as the first teeth erupt. If services are provided at the 6- or 9-month well-child checkup, providers must wait at least 60

calendar days before providing the service again. Ideally, the service should be performed every 3 to 6 months; however, flexibility is allowed to permit scheduling in conjunction with visits for other health services. Please note that the service can be provided until the beneficiary reaches age 3½ (or through age 41 months) since typically the 36-month well-child visit does not occur until after the beneficiary's third birthday.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover physician fluoride varnish services when the criteria specified in **Sections 3.0 and 5.0** of this policy have not been met.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for physician fluoride varnish services.

5.2 American Dental Association Guidelines

Only topical fluoride varnish materials professionally applied as recommended by the guidelines of the American Dental Association Council on Scientific Affairs are accepted for use in the dental care of Medicaid beneficiaries. Specific use of these materials must follow the ADA Council on Scientific Affairs guidelines.

5.3 Limitations or Requirements

By State legislative authority, NC Medicaid applies service limitations to ADA procedure codes as they relate to individual beneficiaries. These service limitations are applied without modification of the ADA procedure description. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*)

beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid beneficiary under age 21. Refer to **Subsection 5.3.3 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**.

5.3.1 Diagnostic: Clinical Oral Evaluation

Code	Description
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver * **replaced procedure codes D0150, D0120, and D1330 effective January 1, 2007** * includes early caries screening, evaluation of caries susceptibility, and recording of other notable findings in the oral cavity * includes preventive oral health and dietary counseling with the primary caregiver * includes prescribing a fluoride supplement, if needed * must be billed in conjunction with D1206 * limited to beneficiaries under 3½ years of age * allowed once every 60 calendar days * limited to six times prior to the beneficiary reaching 3½ years of age * procedure code D1206 must be billed on the detail line before D0145

5.3.2 Preventive: Topical Fluoride Treatment (Office Procedure)

Topical fluoride **must** be applied to **all** teeth erupted on the date of service. Medicaid will only allow reimbursement for this procedure when teeth are present and fluoride varnish is applied to the teeth.

Code	Description
D1206	Topical application of fluoride varnish * **replaced procedure code D1203 effective January 1, 2007** * must be billed in conjunction with D0145 * limited to beneficiaries under 3½ years of age * allowed once every 60 calendar days * limited to six times prior to the beneficiary reaching 3½ years of age * procedure code D1206 must be billed on the detail line before D0145

5.3.3 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid beneficiary under age 21.

All such requests must be submitted in writing prior to delivery of the service. The request must include:

a. a completed CMS-1500 claim form,

b. any materials needed to document medical necessity (e.g., radiographs, photographs), and

c. the completed Non-Covered State Medicaid Plan Services Request Form (for beneficiaries under 21 years of age) or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

Requests should be mailed to:

Assistant Director
Clinical Policy and Programs
Division of Health Benefits
NC Medicaid
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679

If the procedure(s) receives special approval and the beneficiary is Medicaid-eligible on the date the service is rendered, the provider then can file for reimbursement.

Note: A copy of the Non-Covered State Medicaid Plan Services Request Form (for beneficiaries under 21 years of age) can be found on the **EPSDT provider page:** https://medicaid.ncdhhs.gov/

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

6.1.1 Conditions of Participation

Licensed physicians and Non-Physician Practitioners (physician assistant, nurse practitioner, registered nurse, and licensed practical nurse) who meet Medicaid's training requirement can render this service in eligible physicians' offices. All providers participating in the Medicaid program shall provide services in

accordance with the rules and regulations of the Medicaid program. Conditions of participation are made available at the time of provider enrollment.

6.2 Provider Certifications

6.2.1 Provider Training and Continuing Education

Provider training is required as a condition of participation. Providers shall receive Medicaid recognized training to prepare for the delivery of this service. Only providers who have been trained are allowed to render the services and submit claims for payment.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.1.1 Record Retention

Providers are responsible for maintaining all financial, medical and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of not less than six years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations or agreements.

7.2 Oral Screening Requirements

a. Early caries screening and detection of notable findings (obvious pathology of hard and soft tissues) in the oral cavity using a dental mirror and directed light.
b. Counseling and educational materials on good oral hygiene practices and nutrition for children.
c. Prescribing a fluoride supplement, if indicated, per the guidelines of the American Association of Pediatrics: https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary?autologincheck=redirected

   Note: It is critical to have the beneficiary's drinking water tested for fluoride content if the level of fluoride in the source of drinking water is unknown. Providers shall refer the beneficiary to a dentist for continued treatment at the appropriate age based on the beneficiary's need for dental services.
d. Application of the fluoride varnish to all erupted primary teeth, beginning at tooth eruption until the beneficiary is 3½ years of age.

e. Documentation in the beneficiary's health record shall include all of the following:
   1. an oral evaluation and any notable findings;
   2. preventive oral health and dietary counseling with the primary caregiver;
   3. application of fluoride varnish; and
   4. referral to a dentist, if appropriate.

7.3 Application of the Fluoride Varnish

Fluoride varnish is practical, safe, and easy to apply to the teeth of infants and very young children and is extremely useful in the prevention of early childhood caries. Teeth should be wiped with a 2" x 2" gauze pad prior to fluoride varnish application. The varnish is then applied in a thin layer to all surfaces of the teeth using a disposable brush.

7.4 Health Record Documentation

The provider must furnish upon request appropriate documentation, including beneficiary records, supporting material, and any information regarding payments claimed by the Provider, for review by the DHB, its agents, the Centers for Medicare and Medicaid, the State Medicaid Fraud Control Unit of the Attorney General's Office, and other entities as required by law. Providers cannot charge for records requested by Medicaid.

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 2001

Revision Information:

Date	Section Revised	Change
11/01/2007	Section 3.2	The coverage criteria was revised to indicate that the procedure is limited to once every 60 days and the treatment can be covered through the age of 3 ½ years effective with date of service 01/01/2007.
3/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated CDT-2015 procedure code descriptions effective with date of service 1/1/2015.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/04/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/04/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid.

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Note: According to the ICD-10-CM Official Guidelines for Coding and Reporting, the word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

Examples: Provider does not have to be providing a cleaning to use the ICD code listed below.

- Z01.20 (Encounter for dental examination and cleaning without abnormal findings)
- Z01.21 (Encounter for dental examination and cleaning with abnormal findings

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Dental Terminology (CDT 2015).

CDT Code	Description
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D1206	Topical application of fluoride varnish

Note: Procedure code D1206 must be billed on the detail line before D0145.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider (s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

F. Place of Service

The oral screening package is allowed in the physician's office, health department clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and the beneficiary's residence.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

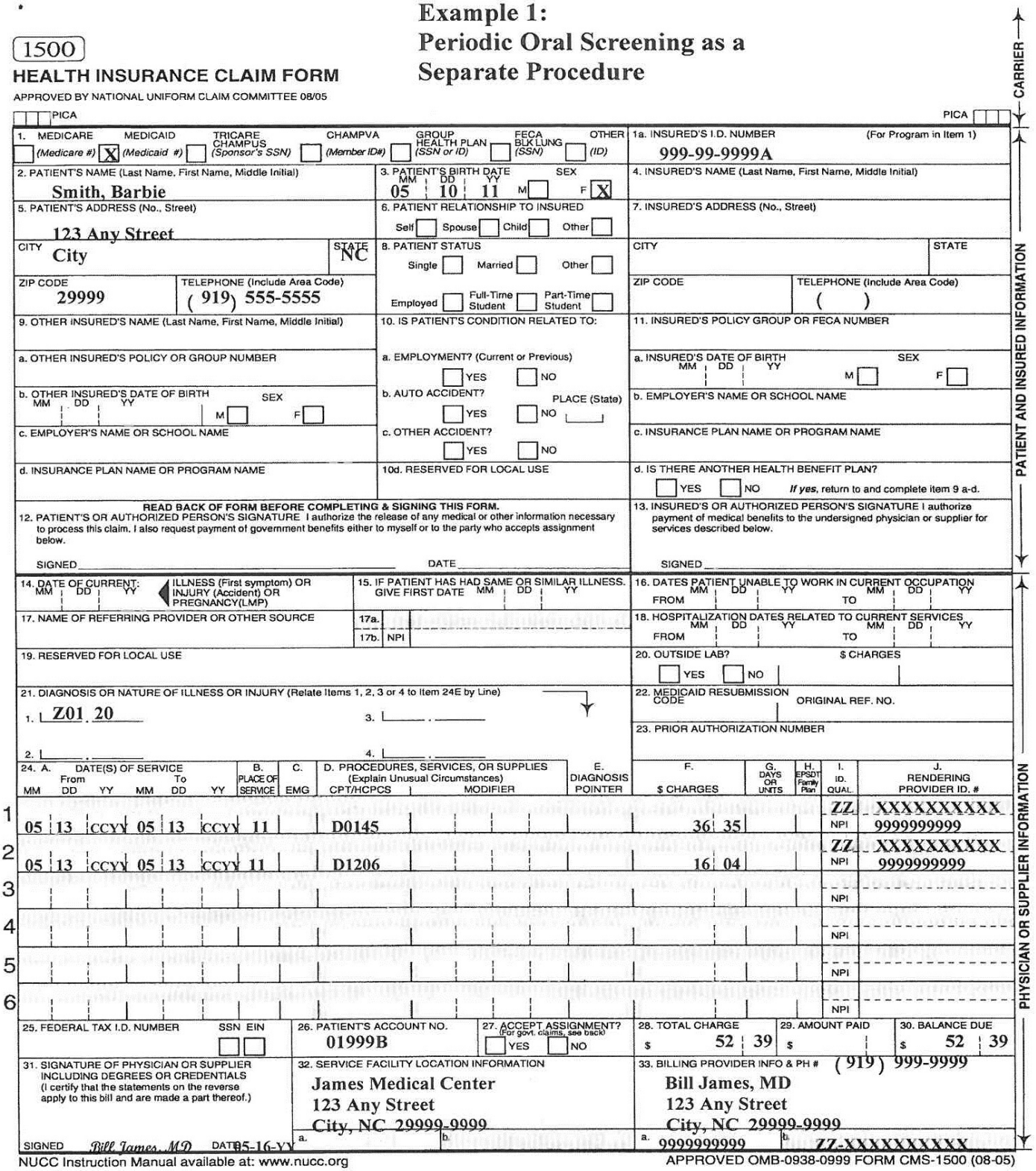
H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

Attachment B: Examples for Filing Physician Fluoride Varnish Claims (CMS-1500 Claim Forms)

The following three examples apply to NC Medicaid and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at www.nucc.org.

Example 1: Periodic Oral Screening as a Separate Procedure



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999-99-9999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Barbie

3. PATIENT'S BIRTH DATE MM 05 DD 10 YY 11 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: City STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): (919) 555-5555

ZIP CODE | TELEPHONE (Include Area Code)

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 NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. Z01.20
2.
3.
4.

22. MEDICAID 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. #
1 05 13 CCYY	05 13 CCYY	11		D0145			36 35			ZZ NPI	XXXXXXXXXX 9999999999
2 05 13 CCYY	05 13 CCYY	11		D1206			16 04			ZZ NPI	XXXXXXXXXX 9999999999
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 01999B

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 52 39

29. AMOUNT PAID $

30. BALANCE DUE $ 52 39

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.)

SIGNED Bill James, MD DATE 05-16-YY

32. SERVICE FACILITY LOCATION INFORMATION
James Medical Center
123 Any Street
City, NC 29999-9999
a.
b.

33. BILLING PROVIDER INFO & PH # (919) 999-9999
Bill James, MD
123 Any Street
City, NC 29999-9999
a. 9999999999 b. ZZ-XXXXXXXXXX

CARRIER

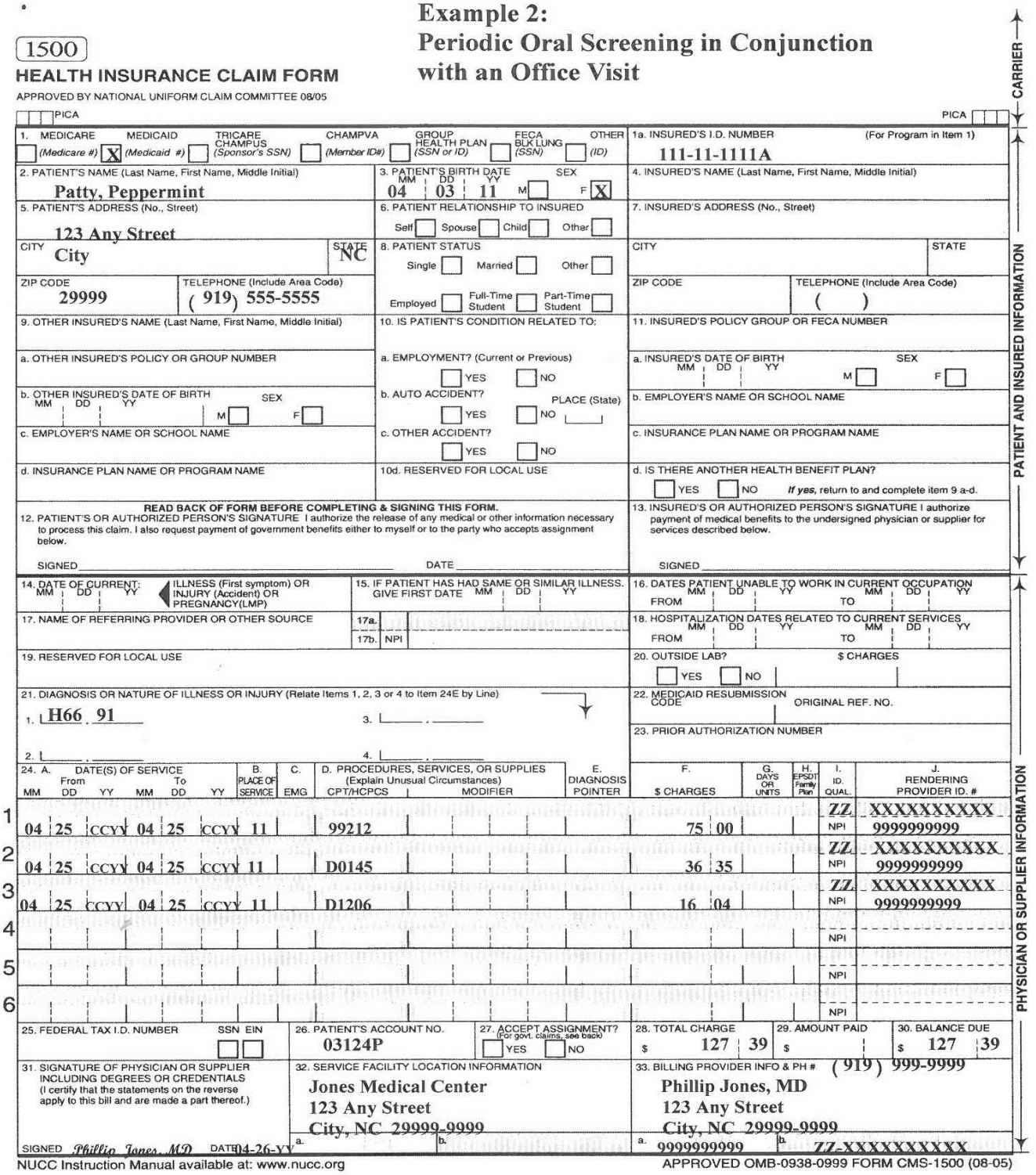
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Example 2:
Periodic Oral Screening in Conjunction with an Office Visit



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 111-11-1111A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patty, Peppermint

3. PATIENT'S BIRTH DATE MM DD YY: 04 03 11 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: City STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): (919) 555-5555

ZIP CODE | TELEPHONE (Include Area Code)

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 NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. H66.91

2.

3.

4.

22. MEDICAID 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. #
1 04 25 CCYY 04 25 CCYY 11			99212			75 00			ZZ NPI	XXXXXXXXXX 9999999999
2 04 25 CCYY 04 25 CCYY 11			D0145			36 35			ZZ NPI	XXXXXXXXXX 9999999999
3 04 25 CCYY 04 25 CCYY 11			D1206			16 04			ZZ NPI	XXXXXXXXXX 9999999999
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 03124P

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 127 39

29. AMOUNT PAID $

30. BALANCE DUE $ 127 39

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.)

SIGNED Phillip Jones, MD DATE 04-26-YY

32. SERVICE FACILITY LOCATION INFORMATION

Jones Medical Center
123 Any Street
City, NC 29999-9999

a. b.

33. BILLING PROVIDER INFO & PH # (919) 999-9999

Phillip Jones, MD
123 Any Street
City, NC 29999-9999

a. 9999999999 b. ZZ-XXXXXXXXXX

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Example 3:
Periodic Oral Screening in Conjunction with Health Check Screening

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
	X					

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	PICA
222-22-2222A	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Brown, Charlie	06 15 11 M X F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Street	Self Spouse Child Other	
CITY: City / STATE: NC	8. PATIENT STATUS	CITY / STATE
	Single Married Other	
ZIP CODE: 29999 / TELEPHONE (Include Area Code): (919) 555-5555	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code): ( )
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 NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. Z00.129 2. 3. 4.		22. MEDICAID 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. #
1 06 23 CCYY 06 23 CCYY 11			99392	EP		80 33		E	ZZ NPI	XXXXXXXXXX 9999999999
2 06 23 CCYY 06 23 CCYY 11			D0145			36 35			ZZ NPI	XXXXXXXXXX 9999999999
3 06 23 CCYY 06 23 CCYY 11			D1206			16 04			ZZ NPI	XXXXXXXXXX 9999999999
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	09878C	YES NO	$ 132 72	$	$ 132 72

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (919) 999-9999
SIGNED *William Smith, MD* DATE 06-24-YY	Smith Medical Center 123 Any Street City, NC 29999-9999 a. b.	William Smith, MD 123 Any Street City, NC 29999-9999 a. 9999999999 b. ZZ-XXXXXXXXXX

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a. 4, 6, 7. 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12. 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.