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.

Table of Contents

Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Child Medical Evaluation

A Child Medical Evaluation (CME) is a medical evaluation where service is provided by a qualified physician, nurse practitioner (NP) or physician assistant (PA) rostered with the North Carolina Child Medical Evaluation Program (CMEP). A CME is provided at the request of child welfare services when they are completing an active assessment due to concerns for child maltreatment.

Medical Team Conference

A medical team conference for child maltreatment is a service provided by an interdisciplinary team of health care professionals, who work with health professionals or community agency representatives to coordinate care when there is suspected child maltreatment.

1.1 Definitions

Child Maltreatment
Child maltreatment is defined as abuse and neglect that occurs to children under 18 years of age. It consists of all types of physical and emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment.

Refer to G.S. § 7B- 101 for a list of definitions that apply to this policy.

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*);

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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. Medicaid

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 a Medicaid Beneficiary 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 both Medicaid

a. The CME must be requested by child welfare services. Medicaid shall cover a CME when a CMEP provider completes the following components:
   1. reason for referral
   2. interviews with
      i. child welfare worker
      ii. caretaker
      iii. an interview with the child, if child is older than three years of age
   3. *case related phone calls
   4. *review of outside health records
   5. physical exam
   6. *laboratory testing and radiology studies

7. summary
    i. overall medical summary
    ii. maltreatment summary
    iii. impact and/or risk of future harm
8. recommendations
    i. medical
    ii. development and mental health
    iii. safety

Note: If any of the components denoted with an asterisk (*) cannot be completed, documentation must clearly state why the component did not take place

b. Medical Team Conference
The provider shall meet with the child before submitting a claim for a medical team conference. A medical team conference is covered when there is suspected child maltreatment, and a physician has a face-to-face case conference with other health professionals or community agency representatives to coordinate care for suspected child maltreatment. Refer to **Attachment A, Section B** for covered diagnoses.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

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 a Medicaid Beneficiary 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 both Medicaid

a. Medicaid shall not cover CME for ANY of the following situations:
    1. The case was not referred by child welfare services.
    2. The case is not in active assessment phase with child welfare services.
    3. Medicaid is not the primary insurance.
    4. The required completed checklist for CME reporting is not attached when the claim is submitted.

5. The provider is not CME rostered with the North Carolina Child Medical Evaluation Program.
6. The provider is not rostered with the North Carolina Child Medical Evaluation Program to conduct the type of diagnostic medical evaluation that was performed.

NOTE: CMEs that are referred only by law enforcement are not eligible for payment through this coverage policy.

b. Medicaid shall not cover a medical team conference when there is no suspected child maltreatment.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval for a CME or a medical team conference.

5.1.1 General

None Apply.

5.1.2 Specific

None Apply.

5.2 Additional Limitations or Requirements

A CME is limited to one per occurrence per day when child maltreatment is suspected. A medical team conference is limited to one per day.

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 and Occupational Licensing Entity Regulations

A CME must be performed by a provider who is actively rostered with North Carolina Child Medical Evaluation Program.

6.2 Provider Certifications

None Apply.

6.3 Mandatory reporting requirements-laws

The provider shall comply with:

a. GS § 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment. Refer to: https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_7B/GS_7B-301.pdf

b. GS § 7B-310 Privileges not grounds for failing to report or for excluding evidence. Refer to: https://www.ncleg.net/enactedlegislation/statutes/html/bysection/chapter_7b/gs_7b-310.html

c. GS § 90-21.20. Reporting by Physicians and hospitals of wounds, injuries and illness. Refer to G.S. § 90-21.20. (c1) "In addition to the reporting requirements of subsection (b) of this section, cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma shall be reported by the physician as soon as it becomes practicable before, during, or after completion of treatment. If the case is treated in a hospital, sanitarium, or other medical institution or facility, the report shall be made by the Director, Administrator, or other person designated by the Director or Administrator of the medical institution or facility, or if the case is treated elsewhere, the report shall be made by the physician or surgeon treating the case to the chief of police or the police authorities of the city or town in this State in which the hospital or other institution or place of treatment is located. If the hospital or other institution or place of treatment is located outside the corporate limits of a city or town, then the report shall be made by the proper person in the manner set forth above to the sheriff of the respective county or to one of the sheriff's deputies. This reporting requirement is in addition to the duty set forth in G.S. 7B-301 to report child abuse, neglect, dependence, or the death of any juvenile as the result of maltreatment to the director of the department of social services in the county where the juvenile resides or is found;" and

d. GS § 7B-309. Immunity of persons reporting and cooperating in an assessment. Refer to: https://www.ncleg.net/EnactedLegislation/Statutes/PDF/BySection/Chapter_7B/GS_7B-309.pdf

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary 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).

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 1993

Revision Information:

Date	Section Updated	Change
4/01/02	Section 8.0, Item # 3	CPT codes replaced state-created code.
12/01/03	Section 2.0	The statement "Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service." was added to this section.
12/01/03	Section 4.0	The sentence "This service is not covered when the medical criteria listed in Section 3.0 are not met." was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.0	This section was reformatted into four subsections; there was no change to the content.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 and 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
11/1/08 (eff. 1/1/08)	Attachment A (was Section 8.0); Section 8.0 (was Section 9.0)	End-dated CPT codes 99361 and 99362 and replaced them with 99367; moved Billing Guidelines to Attachment A, changed the title to Claims-Related Information, and renumbered former Section 9.0.
11/1/08	Throughout	Added text and headings to conform to our current standard statements.
7/1/10	Throughout	Initial promulgation of current coverage for NCHC
8/1/11	Throughout	Policy name changed to Physician Participation in Case Conference for Sexually Abused Children
8/1/11	Sections 1,3,4,5, 6,7, Attachment A	Updated to standard DMA policy language
8/1/11	Attachment A- B. Diagnosis codes	Added ICD-9-CM Code V71.81 Observation and evaluation for suspected abuse and neglect

Date	Section Updated	Change
8/1/11	C. Procedure codes	Deleted 99361 and 99362 with descriptions and comments column.
8/1/11	E. Billing Units	Added 1 unit per day = 1 medical team conference.
8/1/11	F. Place of service	Added Inpatient hospital, outpatient hospital, and office
8/1/11	Subsection 5.2 Limitations	Added: This service is limited to one medical team conference per day.
3/12/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1A-5 under Session Law 2011-145 § 10.41.(b)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
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.
01/01/2019	All Sections and Attachments	Policy title changed from "Physician Participation in Case Conference for Sexually Abused Children" to "Child Medical Evaluation and Physician Participation in Case Conference for Child Maltreatment"
01/01/2019	Section 1.0	Added description related to Child Medical Evaluation (CME). Clarified language related to the definition of a medical team conference.
01/01/2019	All Sections and Attachments	Changed sexually abused children and sexual abuse to child maltreatment.
01/01/2019	Section 1.1	Added definition of child maltreatment. Added G.S. § 7BG.S. 7B- 101 for a list of definitions that may apply to this policy.
01/01/2019	Section 3.2.1	Added information related to CME required services. Clarified language, related to when a medical team conference is covered.
01/01/2019	Section 4.2.1	Added criteria for when a CME is not covered. Clarified language related to medical team conference.
01/01/2019	Section 5.1	Clarified language, related to CME and medical team conference do not require prior approval.
01/01/2019	Section 5.2	Added information related to limitations for CME. Clarified language related to a medical team conference.
01/01/2019	Section 6.1	Added information related to provider qualification, related to CME.
01/01/2019	Section 6.3	Added Section 6.3 – Mandatory reporting requirements-laws,
01/01/2019	Attachment A (B)	Added ICD-10 diagnosis codes: T74.02XA, T74.02XD, T74.02XS, T76.02XA, T76.02XD, T76.02XS

Date	Section Updated	Change
01/01/2019	Attachment A (C)	Added CPT code 99499 and included information related to billing CPT codes 99499 and 99367.
01/01/2019	Attachment A (E)	Added, "One unit per day. One unit = one CME per occurrence."
01/01/2019	Attachment A (H)	Added information related to requirements related to enhanced reimbursement for CME including start date, checklist and claims requirements, instructions to providers to submit checklist and claims to CMEP (Child Medical Evaluation Program) for verification that all requirements have been met. Instructed providers to reference the CMEP website for billing instructions. Instructed that both the CMEP provider and CMEP staff member must sign the checklist. Information related to submitting claims for diagnostic procedures performed during the CME.
01/01/2019	Attachment B	Added attachment B and included a copy of the Checklist for Child Medical Evaluation (CME) Reporting form.
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.
05/15/2021	Attachment A (B)	Added ICD-10 code Z04.42 Encounter for examination and observation following alleged child rape.
05/15/2021	Attachment A (C)	Noted that the physicians, nurse practitioners and physician assistants may only bill for a medical team conference when they are the provider that performed and billed for the child medical evaluation (99499) prior to the medical team conference.
05/15/2021	Attachment A (H)	Deleted, the provider can then submit the claim and checklist to the Department of Health and Human Service fiscal contractor.

Date	Section Updated	Change
05/15/2021	Attachment A (H)	Removed inactive link referencing billing instructions.
05/15/2021	Attachment A (H)	Clarified that claim does not have to be submitted to the CMEP office.
05/15/2021	Attachment B	Replaced DMA-1061: Child Medical Evaluation Checklist to include a Prepaid Health Plan (PHP) name.
05/15/2021		Policy posted 05/18/2021 with an amended date of 05/15/2021
09/01/2022	Section 3.2.1 (a)	Clarified required components for CME to be covered.
09/01/2022	Section 4.2.1 (a) (6)	Added criteria for when a CME is not covered. CME is not covered when the provider is not rostered with the North Carolina Child Medical Evaluation Program to conduct the type of diagnostic medical evaluation that was performed.
09/01/2022	Section 6.3 (a) (b)	Added hyperlinks for GS § 7B-301 and GS § 7B-310.
09/01/2022	Attachment A (B)	Added ICD-10 code Z04.72 Encounter for examination and observation following alleged child physical abuse.
09/01/2022	Attachment A (C)	Deleted: The provider that bills for a CME may be different than the provider who participates in the medical team conference. Clarified the provider must be the same.
09/01/2022	Attachment A (C)	Added Notes: Physicians, nurse practitioners and physician assistants may bill CPT code 99367. CPT code 99170-Anogenital exam, magnified, in childhood for suspected trauma, including image recording when performed, is included in the reimbursement for CPT code 99499 unless a colposcope is used.
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)

Institutional (UB-04/837I 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.

ICD-10-CM Code(s)		
T74.02XA	T74.92XD	T76.32XS
T74.02XD	T74.92XS	T76.92XA
T74.02XS	T76.02XA	T76.92XD
T74.12XA	T76.02XD	T76.92XS
T74.12XD	T76.02XS	Y04.8XXA
T74.12XS	T76.12XA	Z04.42
T74.22XA	T76.12XD	Z04.72
T74.22XD	T76.12XS	Z62.810
T74.22XS	T76.22XA	Z62.811
T74.32XA	T76.22XD	Z62.812
T74.32XD	T76.22XS	
T74.32XS	T76.32XA	
T74.92XA	T76.32XD	

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 Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The following CPT codes are separately billable services. CME and medical team conference must be billed by the same provider with the following CPT codes, respectively.

CPT Code(s)
99499 – Unlisted evaluation and management 99367 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

Note: Physicians, nurse practitioners and physician assistants may bill CPT code 99367.

Note: CPT code 99170-Anogenital exam, magnified, in childhood for suspected trauma, including image recording when performed, is included in the reimbursement for CPT code 99499, unless a colposcope is used.

Note: CPT code 99499 cannot be billed for an exam that is not referred by child welfare services.

Note: Physicians, nurse practitioners and physician assistants may only bill for a medical team conference when they are the provider that performed and billed for the child medical evaluation (99499) prior to the medical team conference.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

One unit per day. One unit = one CME per occurrence.
One unit per day. One unit = one medical team conference.

F. Place of Service

Inpatient hospital, Outpatient hospital, Office

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

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

CMEP providers shall receive enhanced reimbursement for services as part of the CMEP, effective March 1, 2018. This increase in reimbursement applies to Medicaid CMEs that are referred by child welfare services. The increase in reimbursement is for provider's time only. Providers must submit the checklist to CMEP. CMEP shall verify that all components of the bundled service have been met and return the checklist to the provider.

CME claims must be submitted with a completed checklist attachment verifying that all criteria have been met. The checklist must be signed by both the CMEP provider and CMEP staff member. Refer to **Attachment B** of this policy for a copy of the checklist.

Diagnostic procedures performed during the CME can be submitted on a separate claim.

Attachment B: Child Medical Evaluation Checklist

A printable CME Checklist can be found on the CMEP website and on the NC Medicaid website under Provider Forms (Copy below).

Checklist for Child Medical Evaluation (CME) Reporting

Upon an allegation of child abuse / neglect, child welfare/county department of social services may request a CME as a part of the assessment/investigative process. A CME is a specific outpatient medical consultation performed by a qualified medical expert (MD, NP or PA) rostered with the NC Child Medical Evaluation Program. The purpose of the CME is to assist with determining the most appropriate medical diagnoses and treatment plan for a child when it is suspected that a child is being abused or neglected by a parent or other caretaker.

Date of Service: _____

Child's name: _____

DSS Case Number (SIS or Common Name Data Service (CNDS)):

_____

Claim Type: Medicaid as Primary Insurance: Yes ☐ No: ☐

Medicaid Identification Number (MID) (If child has Medicaid): _____

Prepaid Health Plan (PHP): _____

Complete the following if Medicaid is the Primary Insurance:

By submitting this claim into NCTracks, I certify that all **components of the bundled service** (including, the reason for referral, an interview with DSS worker, an interview from the non-offending caregiver, a physical exam of the child, any related phone calls, a review of outside medical records, recommendations and treatment plan for the child and family, and an impression and summary of concerns, if applicable. An interview with the child, if the child is greater than 3 years of age, if appropriate. Laboratory testing and radiology studies may be required, if applicable.) **for CME reporting have been completed** for the above-named beneficiary. I have verified that on this date of service the beneficiary is covered by **Medicaid only**.

Child Medical Evaluation Program (CMEP) Provider National Provider Identifier (NPI): _____

Providers Printed Name: _____

Providers Signature: _____

Questions regarding claims should be submitted to (please provide address/email): _____

_____

_____

CMEP Staff Verification performed by Print Name: _____

CMEP Staff Signature: _____

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