North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance
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Attention:

Direct Enrolled Mental Health Providers and Contracted Entities

Expansion of Provider Types for Outpatient Behavioral Health Services

Providers are responsible for informing their billing agency of information in this bulletin.

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OUTPATIENT BEHAVIORAL HEALTH SERVICES PROVIDED BY DIRECT ENROLLED PROVIDERS

As part of Mental Health Reform, the Area Mental Health Programs will, over time, shift from providing behavioral health services to managing those services. As the first step in accomplishing that goal, the practitioners who wish to participate as independent providers or contracted providers will be required to enroll directly with the Division of Medical Assistance. The Local Management Entities (LMEs) will continue to be a referral source to these private practitioners who will bill Medicaid for their services directly. To assure adequate access to care in the community, Medicaid will enroll a wider range of licensed practitioners than are currently allowed to participate and allow all independently enrolled Mental Health practitioners to treat children and adults.

To implement this expansion the North Carolina Division of Medical Assistance (DMA) is expanding its current coverage of Mental Health services to Medicaid eligible recipients. This expansion allows:

1) direct enrolled Independent Mental Health practitioners to serve Medicaid recipients, regardless of age
2) Additional Mental Health Independent practitioners to enroll directly with the Medicaid Program
3) Services to be provided in additional settings

This expansion allows enrollment of Independent Mental Health practitioners who are in a solo practice, a mental health group practice, or are a contracted provider with another entity. Services will be expanded to include recipients over 21 years of age. This expansion will be effective with dates of service February 1, 2005.

Eligible Providers

As a result of this change, the following Mental Health practitioners are eligible to participate in the Medicaid program:

- Licensed Psychologists (doctorate level)
- Licensed Psychological Associates (LPA)
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Clinical Social Workers (LCSW) with a masters degree in social work from a school of social work accredited by the Council of Social Work Education
- Nurse Practitioners approved to practice in North Carolina and certified by the American Nurses Credentialing Center as an advanced practice nurse practitioner and certified in psychiatric nursing

Note: The Division of Medical Assistance (DMA) will waive the advance psychiatric certification for those nurse practitioners, who are certified in another specialty with four years of documented mental health experience until July 1, 2005. Effective July 1, 2005, nurse practitioners certified in another specialty will need the advanced psychiatric certification.

- Clinical Nurse Specialists certified by the American Nurses Credentialing Center or the American Psychiatric Nurse Association as an advanced practice psychiatric clinical nurse specialist (CNS)
- Certified Clinical Supervisors (CCS)
- Certified Clinical Addictions Specialists (CCAS)

To enroll in the Medicaid program, providers must first complete a provider enrollment application. The provider enrollment application and detailed enrollment requirements can be found on DMA's website at

http://www.dhhs.state.nc.us/dma/provenroll.htmProviders who are currently enrolled as independent mental health practitioners are not required to re-enroll. However, these providers will not be able to receive reimbursement for services provided to recipients age 21 and older until February 1, 2005.

Direct Enrolled Providers Providing Substance Abuse Outpatient Treatment
Professionals, with the exception of physicians or psychologists engaged in private practice, who intend to become directly enrolled providers under Medicaid for the purpose of billing for Substance Abuse Outpatient Treatment must obtain a facility license from the Division of Facilities Services. The requirements for this license are included in the North Carolina Administrative Code for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services 10A NCAC 27G.3500 – Outpatient Facilities for Individuals with Substance Abuse Disorders.

Eligible Recipients

Medicaid eligible recipients may have service restrictions due to their eligibility category that could make them ineligible for Mental Health services. Providers should refer to Basic Medicaid currently listed on the DMA website as General Medicaid Billing/Carolina Access Policies and Procedures Guide http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for detailed information on recipient coverage limitations.

Requirements for and Limitations on Coverage

Medicaid payment for covered services is limited to those services performed by the qualified providers who enroll in the Medicaid program as Independent Mental Health practitioners who are in a solo practice, a mental health group practice, or are a contracted provider with another entity and are issued a provider number from DMA. Services must be medically necessary, individualized, specific, consistent with symptoms or with a confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.

Service Limitations

1. Medicaid does not reimburse for the same services provided by the same provider for the same date of service.
2. Only one psychiatric interview (CPT codes 90801, 90802) by the same provider is allowed in a six-month period.

Referral Requirements

Recipients Under the Age of 21
Services provided to recipients under the age of 21 require a referral by a Carolina ACCESS primary care provider (PCP), the LME or a Medicaid-enrolled psychiatrist.

Referrals may be made by telephone, fax or in writing to the mental health provider. The referring provider will give the mental health provider a referral number that must be placed in block 19 of the CMS-1500 claim

form in order for the claim to be paid. Failure to put the referral number on the claim when filing will result in denial of payment.

Note: Services provided by a physician do not require a referral.

Recipients Age 21 and Over
Services provided to recipients age 21 and over may be self-referred or referred by any source.

Prior Approval Requirements

Dependent on the age of the recipient, Medicaid allows a specific number of unmanaged outpatient mental health visits per calendar year. The number of unmanaged outpatient visits allowed are per recipient per calendar year, not per provider. Therefore, if a recipient is receiving multiple mental health services from more than one provider, the providers will need to coordinate care to determine the number of unmanaged visits that have been utilized.

Procedure codes for group treatment services (90846, 90847, 90849, 90853, 90857, H0005, and H0004 with the appropriate modifier, HR, HS, and HQ) are counted as ½ of an unmanaged visit instead of a whole visit. For example, the recipient may have a combination of four individual visits and eight group visits which would equal eight unmanaged visits; or the recipient may have up to 16 group visits before reaching the trigger point for prior approval. Individual sessions count as one visit. This ½ visit count is only for adult services and pertains only to the 8 unmanaged visits. This does not apply to children or the 26 unmanaged visits allowed to recipients under the age of 21.

Beginning January 1, 2005, CPT code 90862 is counted in the unmanaged visits and is, therefore, not subject to prior approval.

Recipients Under the Age of 21
Coverage is limited to 26 unmanaged outpatient visits per calendar year. Visits beyond 26 per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner, or physician assistant, and prior approval from the utilization review contractor. To ensure timely prior authorization, requests should be submitted prior to the 26th visit.

For services exceeding 26 visits in a calendar year for children, the mental health provider must submit the written request form to Medicaid's utilization review contractor for review and authorization. This form is currently available on ValueOptions website at www.valueoptions.com. After the request is reviewed, the mental health provider will receive notification in writing from the utilization review contractor. The authorization will be entered into Medicaid's claims processing system and is, therefore, not required on the claim. Although prior approval is authorized, the mental health provider must continue to use the PCP, psychiatrist, or LME's referral number in block 19 of the CMS-1500 claim form for recipients under the age of 21.

Recipients Age 21 and Over
Coverage is limited to 8 unmanaged outpatient visits per calendar year. Visits beyond 8 per calendar year require a written order by a medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant, and prior approval from the utilization review contractor.

For services extending beyond 8 visits in a calendar year for adults, the mental health provider must submit the appropriate request form to Medicaid's utilization review contractor for review and authorization. This form is currently available on ValueOptions website at www.valueoptions.com. After the request is reviewed, the mental health provider will receive notification in writing from the utilization review contractor. The authorization will be entered into Medicaid's claim processing system and is, therefore, not required on the claim.

Medicare Recipients
Prior approval is currently not required for recipients with Medicare coverage when the service is paid by Medicare. After July 1, 2005, prior approval will be required when Medicare is the primary payer with the exception of QMB Recipients (Qualified Medicare Beneficiaries).

Place of Service

Independent Mental Health providers can provide services only in specific locations dependent upon the age of the recipient.

Recipients Under the Age of 21
Mental health services provided by Independent Mental Health providers for recipients under the age of 21 are limited to the provider's office, clinic, school, residential facilities, and home.

Recipients Age 21 and Over
Mental health services provided by Independent Mental Health providers for recipients 21 years of age or older are limited to the provider's office, clinic, home, nursing facilities, adult care home, and assisted living facilities.

Consent

The provider is responsible for obtaining the written consent for treatment from recipients of all ages at the time of the initial service.

Coordination of Care

Coordination of care activities are not a Medicaid billable service.

The provider is responsible for the coordination of care activities with the referral source or the recipient's physician which may include but are not limited to the following:

1. written progress or summary reports
2. telephone communication
3. treatment planning processes
4. other activities jointly determined by the referring provider and the behavioral health provider to be necessary for the continuity of care

Documentation Requirements

The independent mental health provider's written agreement with DMA requires the provider to maintain records for each Medicaid recipient documenting the provision of services.

Note: It is not necessary to submit medical record documentation with claims.

Providers must maintain, in each recipient's record, the following documentation (minimum requirements):

1. the recipient's name and Medicaid identification number
2. a description of services performed and dates of service
3. the client response to therapy
4. the duration of service (length of assessment or treatment in minutes)
5. the signature and title of the person providing the service
6. a copy of any testing or summary and evaluation reports
7. documentation of communication regarding coordination of care activities

Recipients Under the Age of 21
Documentation must also include:

1. before the initial visit, referral from a Carolina ACCESS primary care provider, Medicaid-enrolled psychiatrist or local management entity
2. copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 26th visit
3. copy of the completed authorization form and prior approval notification from the utilization review contractor after the 26th visit

Recipients Age 21 and over
Documentation must also include:

1. copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 8th visit

2. copy of the completed authorization form and prior approval notification from the utilization review contractor after the 8th visit

Note: 1. services provided by an LME do not require a referral
2. services provided by a physician do not require a referral or an order
3. written orders and prior approval do not need to be submitted with the CMS-1500 claim form

Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

Claim Type

Providers bill professional services directly to Medicaid's fiscal agent on the CMS-1500 claim form. The direct enrolled provider number needs to be entered in block 33 under the pin field.

Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

Diagnosis Codes Requirements for Recipients Under the Age of 21
Medicaid covers six unmanaged visits without a diagnosis of mental illness.
The first two visits can be coded with ICD-9-CM code 799.9 (a nonspecific code) and the following four visits can be coded with a diagnosis code of V01.0 through V82.9
Or

The first visit can be coded with diagnosis 799.9 and the remaining five can be coded with V01.0 through V82.9
A specific diagnosis code should be used as soon as a diagnosis is established.
Visits seven and beyond require an ICD-9-CM code between 290 through 319.
The range of V codes to be used are diagnosis codes V01.0 through V82.9.

Procedure Codes

Physicians bill appropriate CPT codes which may include Evaluation and Management (E/M) codes. E/M codes are not specific to mental health and are not subject to prior approval. However, these codes are subject to the 24 visit per year limit for adults. For children there is no limit to E/M codes allowed per year.

Mental health specific codes are billable by physicians according to the services they render and are subject to prior approval. Other providers bill specific codes as indicated below:

Professional Specialty	**Related Codes**
Licensed Psychologist	96100, 96110, 96111, 96115, 96117, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Licensed Psychological Associate	96100, 96110, 96111, 96115, 96117, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS
Licensed Professional Counselor	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with an appropriate modifier – HQ, HR, or HS)
Licensed Marriage And Family Therapist	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Licensed Clinical Social Worker	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0004, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)

Procedure codes, continued

Professional Specialty	Related Codes
Nurse Practitioner (Certified)	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90862, 90805, 90807, 90811, 90813, 90815 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Clinical Nurse Specialist (Certified)	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Certified Clinical Supervisor	H0031, H0001, H0005, with all modifiers H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Certified Clinical Addictions Specialist	H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)

Payment is made according to the specialty of the provider delivering the service, whether practicing independently or employed by physicians or clinics.

CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	Type of Coverage	Place an (X) in the Medicaid block.
1a.	Insured's ID Number	Enter the recipient's ten-character identification number found on the MID card.
2.	Patient's Name	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	Patient's Birth Date Sex	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims. Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).
5.	Patient's Address Telephone	Enter the recipient's street address including city, state, and zip code. Entering the recipient's telephone number is optional.
9.	Other Insured's Name	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
15.	If Patient Has Had Same or Similar Illness, Give First Date	Leave blank **Note:** A two-digit year is acceptable on paper claims.
19.	Reserved for Local Use	**Outpatient Behavioral Health Services Recipients under 21:** Enter the referral by a Carolina ACCESS primary care provider, local management entity, or a psychiatrist.
21.	Diagnosis or Nature of Illness or Injury	The written description of the primary diagnosis is not required.
23.	Prior Authorization Number	It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
24A.	Date(s) of Service “From” and “To”	Enter the eight-digit date of service in the "From" block. Example: Record the date of service January 31, 2003 as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. Note: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.
24B.	Place of Service	**Recipients under 21:** Place of service is limited to the providers office, clinic, school, residential facilities, and home. **Recipients age 21 and over:** Place of service is limited to provider’s office, clinic, home, nursing facilities, adult care home, and assisted living facilities.

CMS-1500 Claim Form Instructions, continued

Block	Block Name	Explanation
24D.	Procedures, Services, or Supplies	Enter the appropriate five-digit CPT or HCPCS code. **Note:** Providers mandated to bill modifiers can bill up to three modifiers per procedure code, if applicable. Refer to the **April 1999 Special Bulletin II, Modifiers**, for billing guidelines.
24F.	Charges	Enter the usual and customary charge for each service rendered.
24G.	Days or Units	Enter the number of visits or units.
26.	Patient's Account No.	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
28.	Total Charge	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient were private pay or had Third Party coverage.)
29.	Amount Paid	Effective September 6, 2004 claims filed to Medicare will be crossed automatically to Medicaid for payment if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for that recipient. The Medicare payment should not be entered, attach the Medicare Remittance to the claim. August 2004 Special Medicaid Bulletin V, Medicare Part B Billing.
31.	Signature of Physician or Supplier Including Degrees or Credentials	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Provider Certification for Signature on File form has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
33.	Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.	Enter the billing provider's name, street address including zip code, and phone number. PIN #: Enter the attending direct enrolled seven-character Medicaid provider number. GRP #: Enter the seven-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
11	Office	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Home is considered the recipient's private residence, which also includes an adult care home facility.
32	Nursing Facility	A facility that primarily provides skilled and intermediate nursing care to residents and provides related services for the rehabilitation of injured, disabled or sick persons or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component.
53	Community Mental Health Center	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	Intermediate Care Facility/Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or nursing facility.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
99	Other Unlisted Facility	Other unlisted facilities not identified above, such as a school.

Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

Age – 34
Place of service – office
Self Referral
No Carolina ACCESS
Priced from Attending Provider Number

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 71 SEX M F X

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 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: 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 FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 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. 310 0
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 05	01 01 05	11		90808		134 73	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 134 73

29. AMOUNT PAID $

30. BALANCE DUE $ 134 73

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.)

Signature on file

SIGNED DATE 01/01/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Any Street
Any Town, NC 12345

PIN# 0000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 NCECS Web Based Tool Billing Instructions

With the implementation of standard electronic transactions mandated by HIPAA, N.C. Medicaid launched a web-based claim entry tool called NCECS-Web. The new NCECS-Web claim entry tool requires certain elements for all providers who submit electronic claims. The following guide has been created to assist providers using the NCECS-Web claims entry tool. The guide follows the CMS-1500 claim format.

Specific values are listed, if applicable.

https://webclaims.ncmedicaid.com/ncecs

RECIPIENT INFORMATION		
Field Title	**Required**	**Definition**
Recipient First Name	Yes	Enter the recipient's first name exactly as it appears on the Medicaid ID card. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Recipient Last Name	Yes	Enter recipient's last name exactly as it appears on the Medicaid ID card. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Medicaid ID	Yes	Enter the recipient's ten character Medicaid ID number as it appears on the Medicaid ID card. There are nine numbers followed by one letter in a Medicaid ID number. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Date Field	No	Leave blank.
Patient's Weight (lbs)	No	Leave blank.
Patient Account Number	Yes	Enter the recipient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Prior Authorization Number	No	Leave blank.
Post OP From Date	No	Leave blank.
Post OP Through Date	No	Leave blank.
Medical Record Number	Optional	Enter the recipient's medical record number as assigned by the provider. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.

PROVIDER INFORMATION		
Field Title	**Required**	**Definition**
Provider Last Name or Organization Name	Yes	Name of provider agency filing claim for payment. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Provider First Name	No	Leave blank.
Medicaid Provider Number	Yes	Billing Provider Number as assigned by Medicaid. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
National Provider ID	No	Reserved for future use
Referring Physician Provider No (Carolina Access):	Yes	For recipient's under the age of 21, enter the primary care physician's, local management entities, or Medicaid enrolled psychiatrist's referral number.
CLIA Number	No	Leave blank

MISCELLANEOUS CLAIM INFORMATION		
Field Title	**Required**	**Definition**
EPSDT: Follow-up/No	No	Leave blank.
Release of Information, Yes/No	Yes	Does the provider have a signed release from the patient/recipient allowing the release of information for claims processing? Select "Yes"
EPSDT referral given to patient? Yes/No	No	Leave blank.
EPSDT Referral Type	No	Leave blank.
Paperwork on file at provider site for Medicare override?	No	Leave blank.
Original ICN	Required only when the Claims Submission Reason Code is a 7 or 9	Original Internal Control (claim) Number as assigned to claims by Medicaid.
Place of Service Facility Type Code	Yes	Enter the appropriate code from the Place of Service chart.
Claim Submission Reason Code	Yes, defaults to 1-Original. Drop down box allows user to change to void or replacement	A code that indicates the reason claim has been submitted. It is used to differentiate whether a claim is an original, voided or replacement claim.

MISCELLANEOUS CLAIM INFORMATION, Continued		
Field Title	**Required**	**Definition**
Rendering/Attending Provider First Name	Yes	Enter the providers first name.
Rendering/Attending Provider Last Name	Yes	Enter the providers last name.
Rendering/Attending Medicaid Provider Number	Yes	PIN # - Enter the attending providers eight digit Medicaid provider billing number.
Principal Diagnosis	Yes	Enter the ICD-9-CM code for the principle diagnosis that is responsible for the services rendered.
Additional		Fields for up to 11 additional diagnoses.

Insurance Detail Screen

Field Title	Required	Definition
Other Insurance Responsibility Sequence	When applicable	Indicates hierarchy of responsibility.
Recipient Relationship to the Insured	When applicable	Indicates relationship between the Medicaid recipient for whom claim is being filed and person Insured by other health plan / payer. Relationship may be self if the person is the same.
Other Insurance Claim Filing Indicator	When applicable	Drop-down selection used to describe the type of policy issued by other health plan / payer.
Other Insurance Paid Amount	When applicable	Enter the total amount received from third party sources. Do not enter Medicaid co-payment amount; it will be automatically deducted during claims processing.
Other Insured Last Name	When applicable	Enter the last name of insured on other insurance health plan. May match Medicaid recipient for whom claim is filed.
Other Insured First Name	When applicable	Enter the first name of insured on other insurance health plan. May match Medicaid recipient for whom claim is filed.
Other Insured Member ID	When applicable	Enter the individual identification number for patient, as issued by insurance plan.
Other Insurer Name	When applicable	Enter the name of other insurance company.
Other Insurer Identification Number	When applicable	Enter the identification number from other insurance health plan. Used to indicate group policy numbers.
Other Insurer Claim Paid Date	When applicable	Use only if other insurance is involved in the payment of claim. Enter the date of payment, if applicable.

Service Detail Screen

Field Title	Required	Definition
From Date of Service	Yes	Use a separate detail line for each day that the service is provided. Enter the date of service in the **From** block. Enter the same date in the **To** block.
Through Date of Service	Yes	
Place of Service	Yes	Indicates location where service was rendered. Drop down box offers all valid place of service codes under HIPAA.
HCPCS	Yes	Enter the appropriate five digit CPT code.
Mod 1 through Mod 4	No	Leave blank.
Charge	Yes	Enter the total charge for the units for each date of service on the detail line. (The charges are calculated by multiplying the provider agency's unit rate by the number of units.)
Units	Yes	Enter the number of 15-minute units billed on the detail line. Do not enter an amount in excess of the per day limit.
E/F	No	Leave blank.
DME Days	No	Leave blank.
Claim Note	No	Leave blank.
Line Item Control Number	Optional	Used by provider to enter internal tracking number for service.

NCECS-Web Claims Entry Screen Examples

North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

CMS-1500

Selection Criteria

Claim Type: CMS-1500 Claim ID: 111620041683882824 Save Cancel Delete

Recipient Information

Recipient Last Name: Recipient | Recipient First Name: Jane | Medicaid ID: 123456789P
Date ... ild: | Patient weight(lbs):
P... nt Account Number: 1234P | Medical Record Number: | Post OP from Date:
...ior Authorization Number: | Post OP Through Date:

Provider Information

Provider Last Name or Organization Name: Mental Health Family Care | Provider First Name: Jane
National Provider ID:
Me... id Provider Number: 8300000
...rring Physician Provider No:(Carolina ...ss Physician Number) 1234567 | CLIA Number:

...scellaneous Claim Information

EPSDT: Follow-up No | Release of Information: Yes No
EPSDT referral given to Patient?: Yes No | EPSDT Referral Type:
Paperwork on file at Provider Site for Medicare Override?: Yes No

Related Causes: Auto Accident | State of Auto Accident:
Employment Accident | Date of Accident:
Other Accidental Injury

Original ICN:

Local intranet

1.Complete the recipient last name, recipient first name, Medicaid ID and patient account number fields. Other fields in this section are completed when applicable.

2.Complete provider organization name, referring physician, and Medicaid provider number fields.

NCECS-Web Claims Entry Screen Examples, continued

Address https://webclaims.ncxix.hcg.eds.com/ncecs/

North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

Related Causes: Auto Accident / Employment Accident / Other Accidental Injury

State of Auto Accident:
Date of Accident:

Original ICN:

Place of Service Facility Type Code: 11-Office

Claim Submission Reason Code: 1-Original

Rendering/Attending Information

R/A Provider First Name: Jane

R/A Provider Last Name: Provider

R/A Medicaid Provider Number: 8300000K

CMS-1500 Insurance Detail

Add/Edit Other Insurance

No Other Insurance Total Insurance: 0.00

Diagnosis Codes

Principal: 318

Additional 1 2 3 4 5 6 7 8 9 10 11

CMS-1500 Detail

Add/Edit Details

Dtl Num | From Date of Service | Through Date Of | ... | DME | Line Itm Ctrl
1 | 07/10/2004

Claim Note

3.Enter the code that indicates where the service was rendered.

4.Use only when a payment has been made from a third party source.

5.Enter the ICD-9-CM code with no decimal points.

6.Click here to enter the details of the service provided. See the next page for more information.

NCECS-Web Claims Entry Screen Examples, continued

CMS-1500 Add/Edit Details

Address https://webclaims.ncxix.hcg.eds.com/ncecs/

North Carolina
Electronic Claims Submission

- Main Menu
  - Claims Entry
    - Dental
    - CMS-1500
    - UB-92
  - List Management
  - Reports
    - Dental Submitted Batches
    - CMS-1500 Submitted Batches
    - UB-92 Submitted Batches
  - Claim Submission
    - Claim Submission
  - Reference Materials

CMS 1500 Add/Edit Details

Please complete the following form to create/edit CM

Claim Type: CMS 1500

Recipient Information

Last Name: Recipient

CMS 1500 Detail

	#	From Date of Service	Through Date Of Service	Place of Service	HCPCS/CPT	Mod1	Mod2	Mo
Edit Copy Del	1	07/10/2004	07/10/2004	11	H0036	HI		
Add Clear								

7.Enter the From and To Date of Service, Place of Service, and Procedure Code – then scroll to the right to complete the other fields listed below on the next screen print.

CMS-1500 Add/Edit Details, continued

Address https://webclaims.ncxix.hcg.eds.com/ncecs/

North Carolina
Electronic Claims Submission
Main Menu
Claims Entry
Dental
CMS-1500
UB-92
List Management
Reports
Dental Submitted Batches
CMS-1500 Submitted Batches
UB-92 Submitted Batches
Claim Submission
Claim Submission
Reference Materials

8.Enter the total charge for the day and the total units.
(1 unit= 15 minutes)
After completing each detail, either hit "enter" or scroll back to the left and click on "Add" to record the detail line.

HCPCS/CPT	Mod1	Mod2	Mod3	Mod4	Charge	Units	E/F	DME Days	Line Itm Ctrl Num
H0036	HI				103.45	5		0	0

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA

Age - 4
Place of service - office
No Prior Approval - under 26 unmanaged
Priced from Attending Provider Number

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 111111111X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 01 02 01 SEX M X F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (555)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? PLACE (State) YES NO

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

PATIENT AND INSURED INFORMATION

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 1234567

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. 290 0
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 02 05	01 02 05	11		90802		140 88	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 140 88

29. AMOUNT PAID $

30. BALANCE DUE $ 140 88

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.)

Signature on file

SIGNED DATE 01/01/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

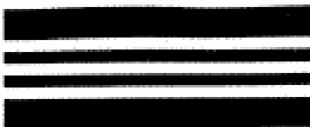
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Dr. Jane Provider
123 Any Street
Any Town, NC 12345

PIN# 0000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Claim Form Examples, continued

PLEASE DO NOT STAPLE IN THIS AREA



Age - 4
Place of service - office
Prior Approval - required
Priced from Attending Provider Number

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 01 04 00 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 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

PATIENT AND INSURED INFORMATION

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 1234567

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. 311 00
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 05 04	01 05 04	11		96117		62 40	1				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 62 40

29. AMOUNT PAID: $

30. BALANCE DUE: $ 62 40

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.)

Signature on file

SIGNED DATE **01/01/05**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

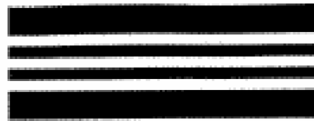
Dr. Jane Provider
123 Any Street
Any Town, NC 12345

PIN# 0000000 GRP# 1111111

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Claim Form Examples, continued

PLEASE DO NOT STAPLE IN THIS AREA



Age - 34
Place of service - office
Self Referral
No Carolina ACCESS
Priced from Attending Provider Number

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA PICA

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 71 SEX M F X

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

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Recipient Town STATE: NC

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

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 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? PLACE (State) YES NO

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

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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. 310 0
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 05	01 01 05	11		90808		134 73	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 134 73

29. AMOUNT PAID $

30. BALANCE DUE $ 134 73

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.)

Signature on file

SIGNED DATE 01/01/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

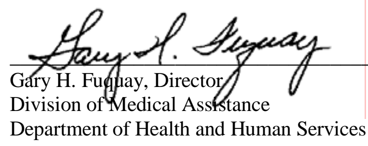
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Any Street
Any Town, NC 12345

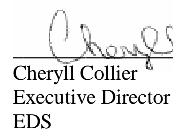
PIN# 0000000 GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



Gary H. Fuquay, Director
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS