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Attention:
All Health Check Providers

Effective July 1, 2005

Health Check
Billing Guide
2005

TABLE OF CONTENTS

HEALTH CHECK EXAMINATION COMPONENTS 1
IMMUNIZATIONS 7
Immunization Administration CPT Codes 90471 and 90472 with the EP Modifier 7
Private Sector Providers 8
Federally Qualified Heath Center and Rural Health Clinic Providers 8
Local Health Department Providers 8
Billing Guidelines for Immunizations 8
Universal Childhood Vaccine Distribution Program/Vaccines for Children Program 9
HEALTH CHECK EXAMINATION SCHEDULES 11
Periodic Examinations 11
Periodicity Schedule 11
Interperiodic Examinations 11
HEALTH CHECK BILLING REQUIREMENTS 12
Requirement 1: Identify and Record Diagnosis Code(s) 12
Requirement 2: Identify and Record Preventive Medicine Code and Component Code 13
Requirement 3: Health Check Modifier – EP 13
Requirement 4: Record Referrals 13
Requirement 5: Next Examination (Screening) Date 14
Systematically Entered Next Examination (Screening) Date 14
Provider-Entered Next Screening (Examination) Date 14
Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier 14
TIPS FOR BILLING 15
All Health Check Providers 15
Private Sector Health Check Providers Only 15
Federally Qualified Health Center and Rural Health Clinic Providers Only 16
HEALTH CHECK COORDINATORS 17
HEALTH CHECK CLAIM FORM SAMPLES 17
N.C. HEALTH SERVICES INFORMATION SYSTEM SCREEN EXAMPLES 37
AMERICAN ACADEMY OF PEDIATRICS POLICY STATEMENT ON DEVELOPMENTAL SURVEILLANCE AND SCREENING OF INFANTS AND YOUNG CHILDREN 40
TIPS FOR DECREASING DENIALS 42
HEALTH CHECK WORKSHEETS 44
Health Check Billing Worksheet 45
Immunization Billing Worksheet 46

Effective with date of service July 1, 2005, please note that for clarity the word "screening" in this guide has been replaced with "examination" or "assessment" as appropriate. For your convenience key words throughout the guide have been bolded or shaded. There are no changes in policy or billing procedures. Please replace the April 2004 Special Bulletin I, *Health Check Billing Guide 2004,* with this special bulletin.

HEALTH CHECK EXAMINATION COMPONENTS

The Health Check Program is a preventive **health** care program for Medicaid-eligible children ages birth through 20. **A Health Check examination is the only well child preventive health visit reimbursed by Medicaid**. Of note, a Health Check preventive health examination is commonly known as a well child check up in the community. All Health Check components are required and must be documented in the child's medical record. These components are based on The American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* found at **http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf.** Each examination component is vital for measuring a child's physical, mental, and developmental growth. Families are encouraged to have their children receive Health Check examinations and immunizations on a regular schedule. In addition, it is the responsibility of each health care facility to create a quality system to follow-up with families whose children are delinquent for preventive health care examinations and to assist those families to schedule appointments for timely examinations. A complete Health Check examination consists of the following age-appropriate components.

- **Comprehensive unclothed physical examination**
- **Comprehensive health history**
- **Nutritional assessment**
- **Anticipatory guidance and health education**
- **Measurements, blood pressure, and vital signs**
  Height, weight, head circumference, growth chart, BMI (Body Mass Index), and vital signs as age appropriate. Blood pressure is recommended to become part of the preventive health examination beginning at age 3 years old.
- **Developmental screening including mental, emotional, and behavioral**
  For infants and young children, the American Academy of Pediatrics (AAP) recommends, "All infants and young children should be screened for developmental delays. Screening procedures should be incorporated into the ongoing health care of the child as part of the provision of a medical home. Developmental surveillance is an important method of detecting delays. Moreover, the use of standardized developmental screening tools at periodic intervals will increase accuracy. For successful early identification of developmental disabilities, the pediatrician must be skilled in screening techniques, seek parental concerns about development and create links to available resources in the community." Please refer to page 40 in this guide for the AAP's recommendations and conclusions from the Policy Statement on Developmental Surveillance and Screening of Infants and Young Children (RE0062), Volume 108, Number 1, July 2001 pp 192-196. The entire policy statement can be found on the AAP website at http://aappolicy.aappublications.org.

Health Check Examination Components, continued

Health Check follows the recommendations of the AAP requiring that a formal, standardized developmental screening tool be used when screening children. A list of screening tools may be accessed on the Developmental and Behavioral Peds website at http://www.dbpeds.org/. **(Please note that the Denver is not found on the list at the Developmental and Behavioral Peds website.)** Two tools, The Ages and Stages Questionnaire (ASQ) and Parents Evaluation of Developmental Status (PEDS) are two such validated first level screening tools, which have been "put to the test" in practices across North Carolina. These are two examples of what is practical, what works in the primary care practice, and what providers will find on the website.

The North Carolina Pediatric Society has endorsed the following schedule for formal, standardized developmental screening: age 6 months; 12 months; 18 or 24 months; and 3, 4, and 5 years of age. The medical record must contain the results of the developmental test.

- **Immunizations:**
  Immunizations must be provided at the time of screening if needed. **It is not appropriate for a Health Check examination to be performed in one location and a child referred to another location for immunizations**. The *Recommended Childhood and Adolescent Immunization Schedule, United States, 2005*, approved by the Advisory Committee on Immunization Practices (ACIP), AAP, and the American Academy of Family Physicians (AAFP) may be found at http://www.cdc.gov/mmwr/pdf/wk/mm5351-Immunization.pdf .

  Note: Please refer to pages 7 and 8 for additional information on immunizations.

- **Vision and Hearing Screenings:**
  In accordance with the periodicity schedule (page 11) and the *Recommendations for Preventive Pediatric Health Care*, **objective** vision assessments (such as using a Snellen chart) are **required** at ages 3 years, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

  In accordance with the periodicity schedule (page 10) and the *Recommendations for Preventive Pediatric Health Care*, objective hearing assessments **using electronic equipment** (audiometer) **must** be performed (in the hospital) at birth , 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

  If the required vision and/or hearing screenings cannot be performed during a periodic visit due to blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

  Note: Please refer to Billing Requirement 2 on page 13 for specific information regarding vision and hearing assessments.

- **Dental Screenings:**
  A dental visit is **required** for every child beginning at 3 years of age. An oral screening performed during a physical examination is not a substitute for examination through direct referral to a dentist. The initial dental referral **must** be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. When any screening indicates a need for dental services at an earlier age (such as baby bottle carries), referrals must be made for needed dental services and documented in the child's medical record. The periodicity schedule for dental examinations is not governed by the schedule for regular health screenings.

  Note: Dental varnishing is not a requirement of the Health Check screening exam. Providers may bill for dental varnishing and receive reimbursement in addition to the Health Check examination. Refer to the August 2002 general Medicaid bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm for billing codes and guidelines.

- **Laboratory Procedures:**
  Includes hemoglobin or hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead testing.

  Note: Medicaid will not reimburse separately for these laboratory tests when performed during a Health Check examination.

  Hemoglobin or Hematocrit
  Hemoglobin or hematocrit **must** be measured once during infancy **(preferably** between the ages of 9 and 12 months) for all children and once during adolescence for menstruating adolescent females. An annual hemoglobin or hematocrit for adolescent females (ages 11 to 21 years) must be performed if any of the following risk factors are present: Moderate to heavy menses, chronic weight loss, nutritional deficit or athletic activity.

  If the provider has a documented normal result of a hemoglobin or hematocrit preformed by another provider within three months of the date of the Health Check screening, repeating the hemoglobin or hematocrit is not required as part of the Health Check visit unless the provider feels that this test is needed. The result and source of the test must be documented in the child's medical record.

  The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has specific guidelines for hematocrit/hemoglobin testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information. For more information on guidelines and time frames, call the local WIC office.

  Urinalysis
  AAP recommends that a urinalysis be performed during the 5-year-old periodic examination as well as during periodic examinations for all sexually active males and females.

  Sickle Cell Testing
  North Carolina hospitals are required to screen all newborns for sickle cell disease prior to discharge from the hospital. If a child has been properly tested, this test need not be repeated. **Results must be documented in the child's medical record.** If the test result of the newborn sickle cell is **not** readily available, contact the hospital of birth. An infant without documentation of being tested at birth should receive a sickle cell test prior to 3 months of age.

  If the child is under 3 months of age and there is no sickle cell result in the medical record, then the test must be repeated. If the child is 3 months of age or older, and there is no sickle cell test result in the record, the test should be repeated if the provider feels it is indicated.

Tuberculin Testing
Reviewing perinatal histories, family and personal medical histories, significant events in life, and other components of the social history will identify children/adolescents for whom TB screening is indicated. **If none of the screening criteria listed below are present, there is no recommendation for routine TB screening.**

The North Carolina TB Control Branch is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

Tuberculin testing should be performed as clinically indicated for children/adolescents at increased risk of exposure to tuberculosis, **via Purified Protein Derivative (PPD) intradermal injection/Mantoux method** – not Tine Test.

Criteria for screening children/adolescents for TB (per the NC TB Control Branch) are:

1. Children/adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.

2. Perform a **baseline screen** when these children/adolescents present for care.

    a. Foreign-born individuals arriving within the **last five years** from Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand, and countries in Western Europe.
    b. Children/adolescents who are migrants, seasonal farm workers or are homeless.
    c. Children/adolescents who are HIV-infected.
    d. Children/adolescents who inject illicit drugs or use crack cocaine.

Subsequent TB skin testing is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

In addition to the TB Control Branch criteria:
A TB screening performed as a part of a Health Check screening **cannot** be billed separately.

Lead Screening

Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should perform a lead screening when it is clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial screening. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

Blood Lead Concentration	Recommended Response
<10 ug/dL	**Rescreen at 24 months of age**
10 through 19 ug/dL	**Confirmation (venous) testing should be conducted within three months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on three consecutive tests (venous or finger stick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered.
20 through 44 ug/dL	**Confirmation (venous) testing should be conducted within 1 week.** If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on three consecutive tests (venous or finger stick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	**The child should receive a venous lead test for confirmation as soon as possible**. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Screening

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results from specimens of children outside this age group need to contact the State Laboratory of Public Health at 919-733-3937.

IMMUNIZATIONS

Immunization Administration CPT Codes 90471 and 90472 with the EP Modifier

Medicaid reimburses providers for the administration of immunizations to Medicaid-enrolled children, birth through 20 years of age, using the following guidelines. **Always use the EP modifier when billing 90471 and 90472.**

Private Sector Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check examination or an office visit.

- Administration of one immunization is billed with the administration CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPT code 90472 with the **EP** modifier and are reimbursed at $13.71.

The maximum reimbursement for two or more immunizations is $27.42 when using both CPT codes 90471 and 90472. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D of the CMS-1500 claim form. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on billing an immunization administration fee, refer to the chart on page 8.

Federally Qualified Health Center or Rural Health Clinic Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check examination. Health Check examinations and the immunization administration fees are billed using the provider's Medicaid number with the "C" suffix.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPT code 90472 with the **EP** modifier and are reimbursed at $13.71.

An immunization administration fee cannot be billed in conjunction with a core visit. Report the immunization given during the core visit without billing the administration fee. For instructions on billing an immunization administration fee, refer to the chart on page 8.

Local Health Department Providers

An immunization administration fee may **not** be billed if the immunization(s) is provided in addition to a Health Check examination. The immunization administration CPT codes 90471 with the **EP** modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit**.

- Administration of one or more immunizations is billed with the CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $20.00.

The immunization administration code is reimbursed at $20.00 regardless of the number of immunizations given. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on how to bill an immunization administration fee, refer to the chart on page 8.

BILLING GUIDELINES FOR IMMUNIZATIONS

Provider Type	Health Check Examination with Immunization(s)	Immunization(s) Only	Office Visit with Immunization(s)	Core Visit with Immunization(s)
Private Sector Providers	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. One immunization diagnosis code is required. Immunization procedure code(s) are required.	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	N/A
FQHC/RHC	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. One immunization diagnosis code is required. Immunization procedure code(s) are required.	N/A	Cannot bill 90471 or 90472. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.
Local Health Department Providers	Cannot bill 90471. Must report immunizations. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one or more immunizations, bill 90471 with the EP modifier. One immunization diagnosis code is required. Immunization procedure code(s) are required.	For one or more immunizations, bill 90471 with the EP modifier. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.	N/A

Immunization procedure code(s) must be listed in block 24D of the CMS-1500 claim form for all immunizations administered.

Universal Childhood Vaccine Distribution Program/Vaccines for Children Program

The Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program provides at no charge all required (and some recommended) vaccines to North Carolina children birth through 18 years of age according to the recommendations of the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Due to the availability of these vaccines, Medicaid does not reimburse for UCVDP/ VFC vaccines for children ages birth through 18. An exception to this is noted in the table below.

For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the VFC program vaccines, Medicaid will reimburse providers for Medicaid-covered vaccines.

The following is a list of UCVDP/VFC vaccines:

Codes	Vaccines	Diagnosis Codes
90648	Hib-4 dose PRP-T (ActHib)	V03.8 or V05.8
90655	Influenza , preservative free (6 through 35 months of age) **High-Risk Only for 24 months and older**	V04.81
90657	Influenza (6 to 35 months of age) **High-Risk Only for 24 months and older**	V04.81
90658	Influenza (3 years of age and above) **High-Risk Only**	V04.81
90669	Pneumococcal - PCV7 (2 through 59 months of age) **High-Risk Only for 24 through 59 months**	V03.82 or V05.8
90700	DtaP	V06.8
90702	DT	V06.8
90707	MMR	V06.4
90713	IPV	V04.0
90716	Varicella	V05.4
90718	Td	V06.5
90723	Combination DTAP, Hepatitis B and IPV (> 2 months through 6 years of age)	V06.8
90732	Pneumococcal - PPV23	V03.82 or V05.8
90744	Hepatitis B Vaccine – Pediatric/Adolescent If the first dose of Hepatitis B vaccine is administered prior to the 19th birthday, UCVDP vaccine can be used to complete the series prior to the 20th birthday.	V05.8

Note: Hepatitis A and Twinrix (Hep A/B combination) are available at certain ages and under certain criteria through the VFC program. For more information you may contact the Immunization Branch at 919-733-7752 or the Immunization Branch Website at http://www.immunizenc.com.

UCVDP/VFC, continued

North Carolina Medicaid providers who are not enrolled in the UCVDP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-800-344-0569.

Out-of-state providers (within the 40-mile radius of North Carolina) may obtain VFC vaccines by calling their state VFC program. VFC program telephone numbers for border states are listed below:

- **Georgia** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-532-8513
- **Virginia** 1-804-786-6246

HEALTH CHECK SCREENING SCHEDULES

Periodic Examinations
The **preventive medicine CPT codes 99381 through 99385 with the EP modifier, and 99391 through 99395 with the EP modifier** are used to bill a periodic Health Check examination. (Refer to Health Check Billing Requirements on page13.)

The schedule listed below outlines the recommended frequency of Health Check examinations dependent upon the age of the child. This schedule is based on AAP's *Recommendations for Preventive Pediatric Health Care*.

Note: If an illness is detected during a Health Check examination, the provider may continue with the examination **or** bill a sick visit and reschedule the Health Check examination for a later date.

Periodicity Schedule

Within the first month	2 years	12 years
2 months	3 years	15 years
4 months	4 years	18 years
6 months	5 years	
9 **or** 15 months	6 years	
12 months	9 years	
18 months	12 years	

Interperiodic Examinations
The **preventive medicine CPT codes 99381 through 99385 with the EP modifier, and 99391 through 99395 with the EP modifier** are used to bill an interperiodic Health Check examination. (Refer to Health Check Billing Requirements on page 13.)

In addition to the periodicity schedule, interperiodic Health Check examinations are allowed in the following circumstances:

- When a child requires either a kindergarten or sports physical **outside** the regular schedule.
- When a child's physical, mental or developmental illnesses or conditions have already been diagnosed and there are indications that the illness or condition may require closer monitoring.
- When the provider has determined there are medical indications that make it necessary to schedule additional examinations in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis or treatment.
- Upon referral by a health, developmental or educational professional based on their determination of medical necessity. Examples of referral sources may include Head Start, Agricultural Extension Services, Early Intervention Programs or Special Education Programs.

In each of these circumstances, the provider must specify and document in the child's medical record the reason necessitating the interperiodic examination.

Developmental screenings and hearing and vision screenings are not required for an interperiodic examination. **All other age-appropriate Health Check components must be performed during an interperiodic Health Check examination.**

HEALTH CHECK BILLING REQUIREMENTS

Instructions for billing a Health Check examination on the CMS-1500 claim form are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are as follows:

Requirement 1: Identify and Record Diagnosis Code(s)

Place diagnosis code(s) in the correct order in block 21. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Periodic Health Check Examination – Use V20.2 as the Primary Diagnosis

The primary diagnosis V20.2 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V20.2) and **always** before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Interperiodic Health Check Examination – Use V70.3 as the Primary Diagnosis

The primary diagnosis V70.3 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V70.3and **always** before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Requirement 2: Identify and Record Preventive Medicine Code and Component Codes

The preventive medicine CPT code with the EP modifier for Health Check examinations should be billed as outlined below. In addition to billing the preventive medicine code, developmental screening, vision and hearing CPT codes must be listed based on the ages outlined in the Health Check Examination Components indicated on page 1.

- A Health Check examination is the only well child visit reimbursed by Medicaid and must have V20.2 or V70.3 listed on the claim form as the primary diagnosis code.

- A developmental screening CPT code with the EP modifier **must** be listed in addition to the preventive medicine CPT codes for a periodic Health Check examination when age appropriate. No additional reimbursement is allowed for this code. Private providers may refer to pages 19, 21, 22, 23, 24 and 26 for sample claims. Rural Health providers may refer to page 33 for a sample claim. Local health departments may refer to pages 37 and 38 for sample HSIS screens.

- Vision CPT codes with the EP modifier **must** be listed on the claim form in addition to the preventive medicine CPT codes for a periodic Health Check examination. No additional reimbursement is allowed for these codes. Private providers may refer to pages 24 and 26 for sample claims on. Rural Health providers may refer to pages 31, 32, and 34 for sample claims. Local health departments may refer to pages 37 and 38 for sample HSIS screens.

- Hearing CPT codes with the EP modifier **must** be listed on the claim form in addition to the preventive medicine CPT codes for a periodic Health Check examination. No additional reimbursement is allowed for these codes. Private providers may refer to pages 20, 24, and 26 for sample claims. Rural Health providers may refer to pages 32 and 35 for sample claims. Local health departments may refer to pages 37 and 38 for sample HSIS screens.

Health Check Billing Requirements, continued

Use the correct Health Check examination preventive medicine codes with the EP modifier in block 24D of the CMS-1500 claim form:

Examination	Preventive CPT Codes and Modifier	Diagnoses Codes
Periodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D Developmental Screening CPT Code 96110; at 6 months of age, 12 months of age, 18 or 24 months of age, at age 3, 4, and 5 years old EP Modifier is required in block 24D Vision CPT code 99172 or 99173; beginning at age 3 EP Modifier is required in block 24D Hearing CPT code 92551, 92552, or 92587; beginning at age 4 EP Modifier is required in block 24D	V20.2 Primary Diagnosis
Interperiodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D	V70.3 Primary Diagnosis

Requirement 3: Health Check Modifier – EP

The Health Check CPT codes for periodic and interperiodic examinations must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. The vision, hearing, and developmental screening CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. EP is a required modifier for all Health Check claims.

Requirement 4: Record Referrals

N.C. Medicaid is HIPAA-compliant and is able to receive standard electronic HIPAA transactions.

Providers billing electronically using the services of a vendor or clearinghouse may reference the National HIPAA Implementation Guide and the North Carolina 837 Professional Claim Transaction Companion Guide for values regarding follow up-visits. The National HIPAA Implementation Guide for the 837 Claim Transaction can be accessed at http://www.wpc-edi.com.

The North Carolina Medicaid 837 Companion Guide can be accessed on the DMA website at http: http://www.dhhs.state.nc.us/dma/hipaa/837prof.pdf.

For providers billing on paper, a referral code indicator is used when a follow-up visit is necessary for a diagnosis detected during a Health Check examination. The indicator "R" should be listed in block 24H 19 and 20 for sample claims. Rural Health providers may refer to page 33 for a sample claim.

Local health departments may refer to page 37 for a sample HSIS screen.

Health Check Billing Requirements, continued

Requirement 5: Next Screening Date

Providers billing on paper may enter the next (screening) examination date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form.

Systematically Entered Next Examination Date; Paper Providers

Providers have the following choices for block 15 of the CMS-1500 claim form with a Health Check examination. All of these choices will result in an automatically entered NSD.

Leave block 15 blank.

- **Place all zeros in block 15 (00/00/0000).**
- **Place all ones in block 15 (11/11/1111).**

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

Provider-Entered Next Examination Date; Paper Providers

Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is out of range with the periodicity schedule, the system will override the provider's NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

Note: Providers billing electronically are not required to enter a next (screening) examination date (NSD) for health check screening claims.

Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier

All providers should refer to the chart on page 8 for guidelines on when to bill the immunization administration CPT codes and the EP modifier.

When billing one immunization, private providers must use the administration CPT code 90471 (one unit) with the EP modifier listed in block 24D.

When additional immunizations are provided, private providers must use the administration CPT code 90472 with the EP modifier listed in block 24D.

Private providers may refer to pages 22, 23, 24, 25 26 and 27 for sample claims. Rural Health providers may refer to pages 33 and 36 for sample claims. Local health departments may refer to pages 38 and 40 for sample HSIS screens.

Note: If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90471 and 90472 is $0.00.

TIPS FOR BILLING

All Health Check Providers

- Two Health Check examinations on different dates of service cannot be billed on the same claim form.

- A formal, standardized developmental screening tool **must** be used during periodic examinations for children ages 6 months, 12 months, 18 or 24 months, and 3, 4, and 5 years of age.

- If the required vision and/or hearing screenings cannot be performed during a periodic visit due to a condition such as blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

- When billing immunization administration CPT codes, the EP modifier must be entered in block 24D to receive the reimbursement rate of $13.71 for 90471 (health departments receive $20.00) and $13.71 for 90472 (no additional reimbursement for health departments). If the EP modifier is not entered in block 24D, the reimbursement will be $0.00 per unit. The reimbursement for these codes is $3.41 per unit for non-Health Check related services. Local health departments should follow directions on pages 7 and 8when billing these codes.

- Third party insurance must be pursued and reported in block 29 of the CMS-1500 claim form when preventive services (well child examinations) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit the claim to Medicaid.

Private Sector Health Check Providers Only

- A Health Check examination and an office visit with different dates of service cannot be billed on the same claim form.

- A Health Check examination and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.

- Immunization administration CPT code 90471 with the EP modifier and 90472 with the EP modifier can be billed with a Health Check examination, office visit or if it is the only service provided that day. When billing in conjunction with a screening CPT code or an office visit code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with the EP modifier and 90472 with the EP modifier) as the only service for that day, providers are required to use an immunization diagnosis in block 21 of the claim form. **Always list immunization CPT procedure codes** when billing 90471with the EP modifier and 90472 with the EP modifier. Refer to the chart on page 8 and the sample claim forms beginning on pages 22 through 31.

- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for the Health Check examination and the amount billed for immunizations and any other service billed on the same date of service. Thus, it is necessary to check claim status for two separate claims.

Federally Qualified Health Center and Rural Health Clinic Providers Only

- FQHCs and RHCs must bill Health Check services using their Medicaid provider number with the "C" suffix.

- A Health Check examination and a core visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.

- Immunization administration CPT code 90471 with the EP modifier and 90472 with the EP modifier can be billed if it is provided in addition to a Health Check examination CPT code or if it is the only service provided that day. When billing in conjunction with a examination code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with the EP modifier and 90472 with the EP modifier) as the only service for that day, an immunization diagnosis code is required to be entered in block 21 of the claim form. The administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list immunization procedure codes in the appropriate block on the claim form. **Always list immunization procedure codes** when billing 90471 with the EP modifier and 90742 with the EP modifier. Refer to the chart on page 8 and the sample claim forms on pages 32 through 37.

HEALTH CHECK COORDINATORS

Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services. The roles of the HCCs include, but are not limited to the following:

- using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- assisting families to use the health care services in a consistent and responsible manner
- assisting with scheduling appointments or securing transportation
- acting as a local information, referral, and resource person for families
- providing advocacy services in addressing social, educational or health needs of the recipient
- initiating follow-up as requested by providers when families need special assistance or fail to bring children in for preventive health examinations
- promoting Health Check and health prevention with other public and private organizations

Physicians, PCPs, and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and helps make preventive health care services more timely and effective.

HCCs are currently located in 89 North Carolina counties and Qualla Boundary.

HCCs are housed in local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA website at http://www.dhhs.state.nc.us/dma.

HEALTH CHECK CLAIM FORM SAMPLES

There are 17 CMS-1500 claim form samples, including two split claims (pages 24/25 and 26/27), and six examples of HSIS screens on the following pages.

Note: A copy of the back of the CMS-1500 claim form precedes the first sample. The back of the CMS claim form includes important information regarding Medicaid payments. The section on Medicaid Payments (Provider Certification) specifies that the provider of Medicaid services agrees 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-payments or similar cost-sharing charges.

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)

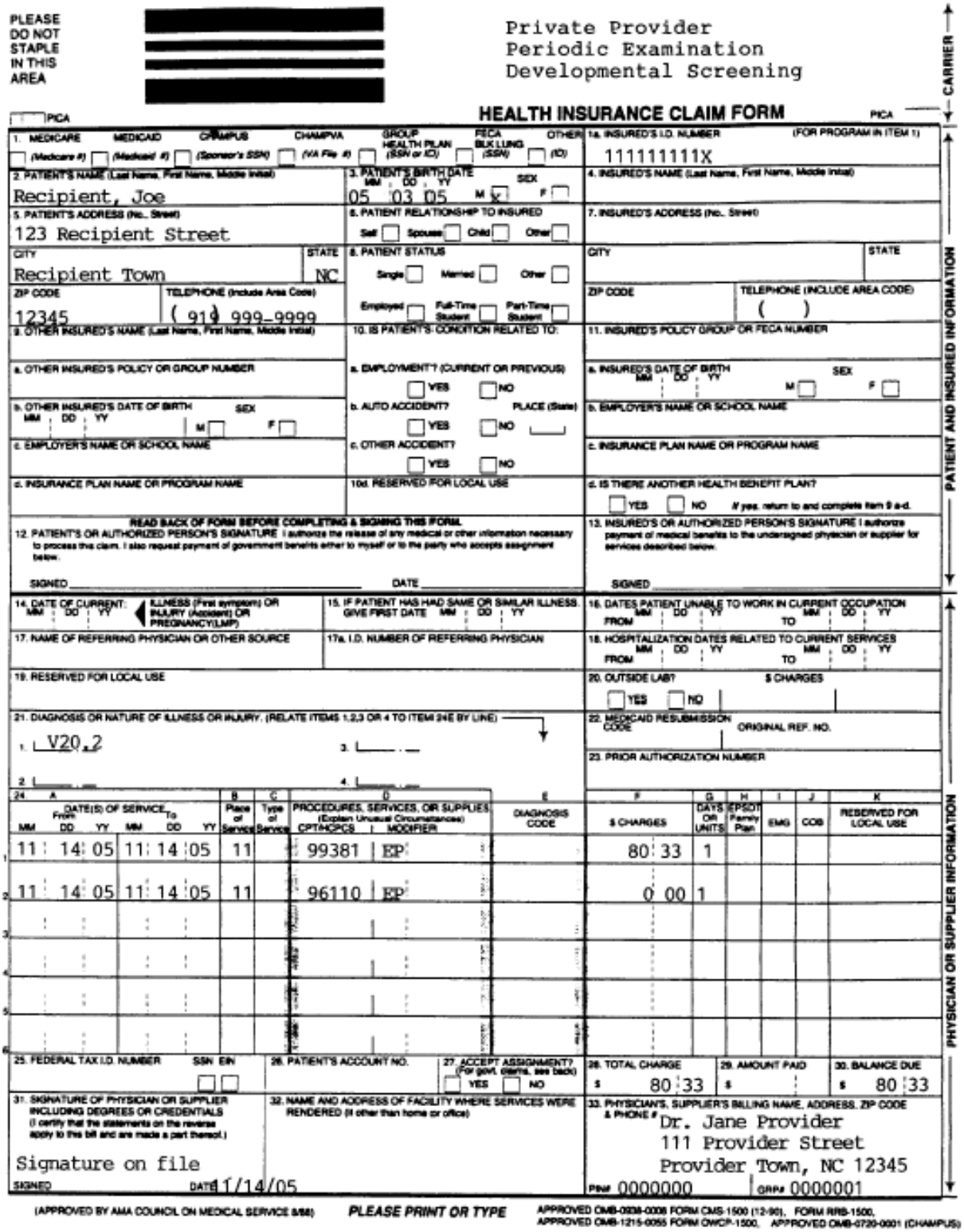
I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

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, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Periodic Examination
Developmental Screening

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | 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: 05 03 05 | SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 123 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): (919) 999-9999

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

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

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. V20.2 3. ___ 2. ___ 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
1	11 14 05 | 11 14 05	11		99381	EP		80 33	1				
2	11 14 05 | 11 14 05	11		96110	EP		0 00	1				
3												
4												
5												
6												

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 $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

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 11/14/05

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 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 0000001

CARRIER

PATIENT AND INSURED INFORMATION

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)

Private Provider
Periodic Examination
Vision and Hearing

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | 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, Jane

3. PATIENT'S BIRTH DATE: MM 06 DD 04 YY 02 | SEX: M ☐ 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): (919) 999-9999

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.

PATIENT AND INSURED INFORMATION

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

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

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. V20.2 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
07 04 05	07 04 05	11		99392	EP		80 33	1				
07 04 05	07 04 05	11		96110	EP		0 00	1				
07 04 05	07 04 05	11		99173	EP		0 00	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 $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

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 07/04/05

SIGNED DATE

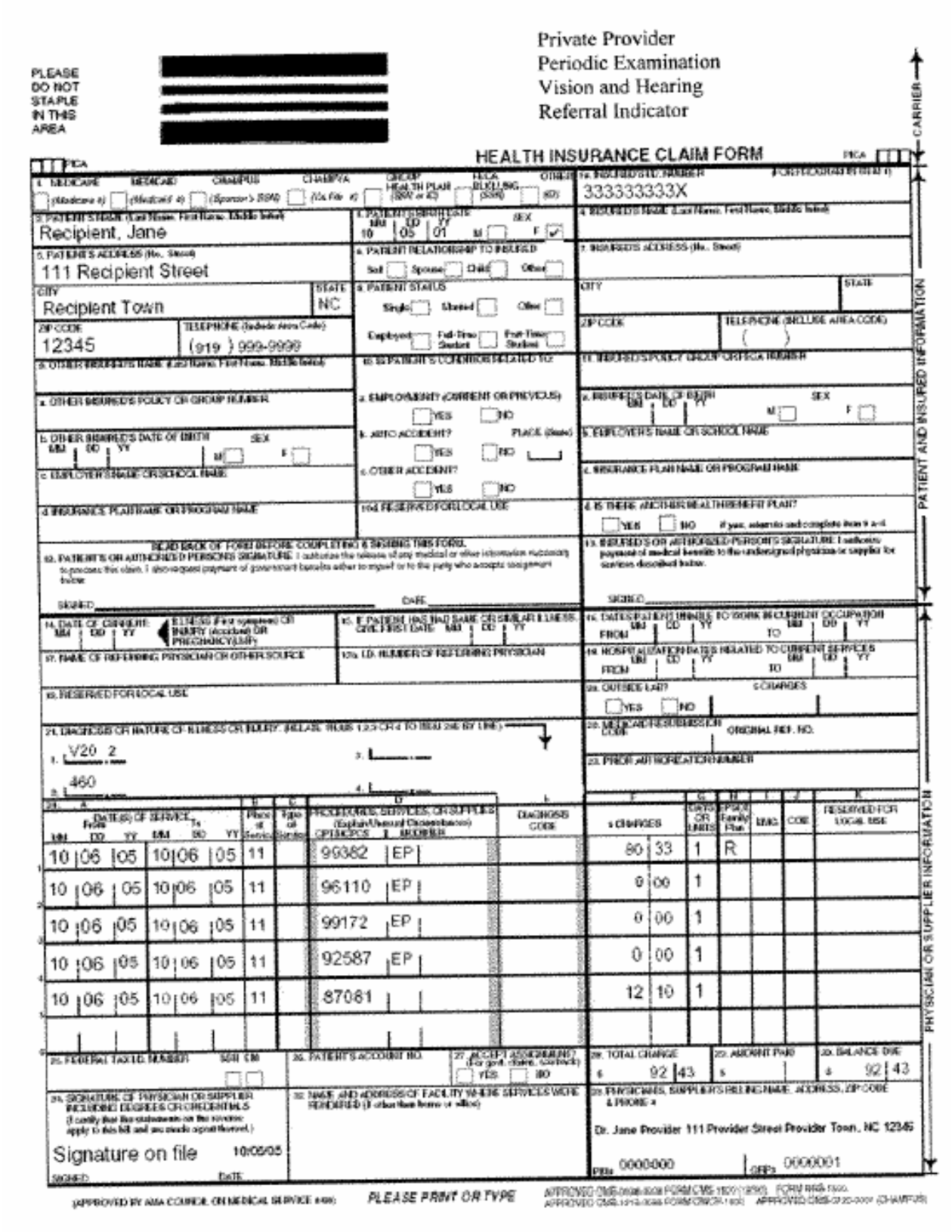
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

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

PIN# 0000000 GRP# 0000001

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 4/90) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (2/90) FORM HCFA-1500. APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)



Private Provider
Periodic Examination
Vision and Hearing
Referral Indicator

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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: 333333333X

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

3. PATIENT'S BIRTH DATE: 10 05 01 SEX: M 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): (919) 999-9999

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: SEX M F

b. OTHER INSURED'S DATE OF BIRTH: 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

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

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. V20.2
2.
3.
4. 460

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	DIAGNOSIS CODE	E. $ CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. EMG	I. COB	J. RESERVED FOR LOCAL USE
10 06 05	10 06 05	11		99382	EP		80 33	1	R			
10 06 05	10 06 05	11		96110	EP		0 00	1				
10 06 05	10 06 05	11		99172	EP		0 00	1				
10 06 05	10 06 05	11		92587	EP		0 00	1				
10 06 05	10 06 05	11		87081			12 10	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: $ 92 43

29. AMOUNT PAID: $

30. BALANCE DUE: $ 92 43

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 10/05/05

SIGNED DATE

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 Provider Street Provider Town, NC 12345

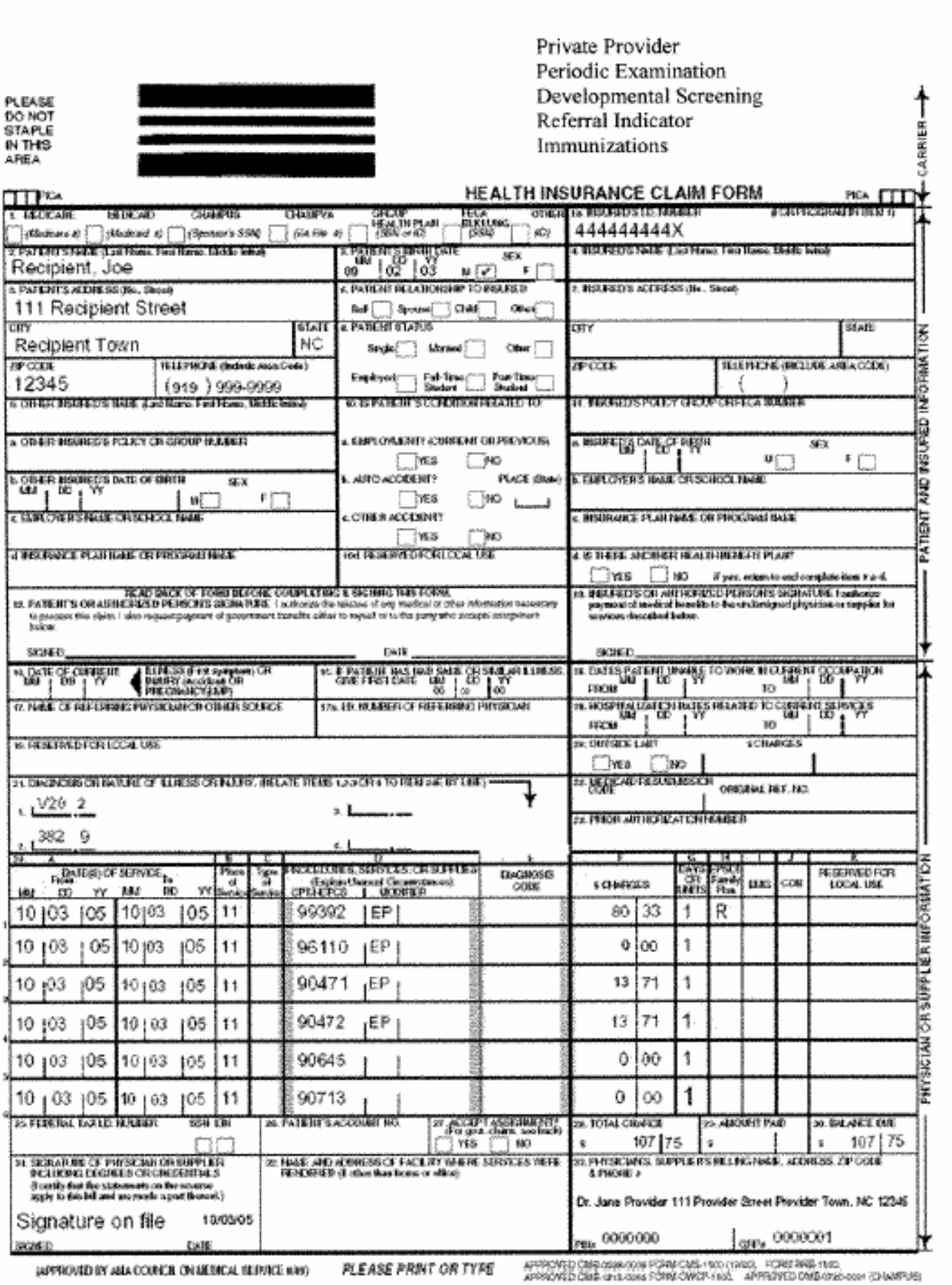
PIN# 0000000 GRP# 0000001

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 4-89) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90) FORM RRB-1500. APPROVED OMB-1215-0060 FORM OWCP-1500 APPROVED OMB-0720-0001 (CHAMPUS)



Private Provider
Periodic Examination
Developmental Screening
Referral Indicator
Immunizations

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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: 444444444X

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

3. PATIENT'S BIRTH DATE: MM 09 DD 02 YY 03 SEX: M ✓ 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): (919) 999-9999

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

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

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. V20 2
2. 382 9
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
10 03 05	10 03 05	11		99392	EP		80 33	1	R			
10 03 05	10 03 05	11		96110	EP		0 00	1				
10 03 05	10 03 05	11		90471	EP		13 71	1				
10 03 05	10 03 05	11		90472	EP		13 71	1				
10 03 05	10 03 05	11		90645			0 00	1				
10 03 05	10 03 05	11		90713			0 00	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 $ 107 75

29. AMOUNT PAID $

30. BALANCE DUE $ 107 75

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 10/03/05

SIGNED DATE

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 Provider Street Provider Town, NC 12345

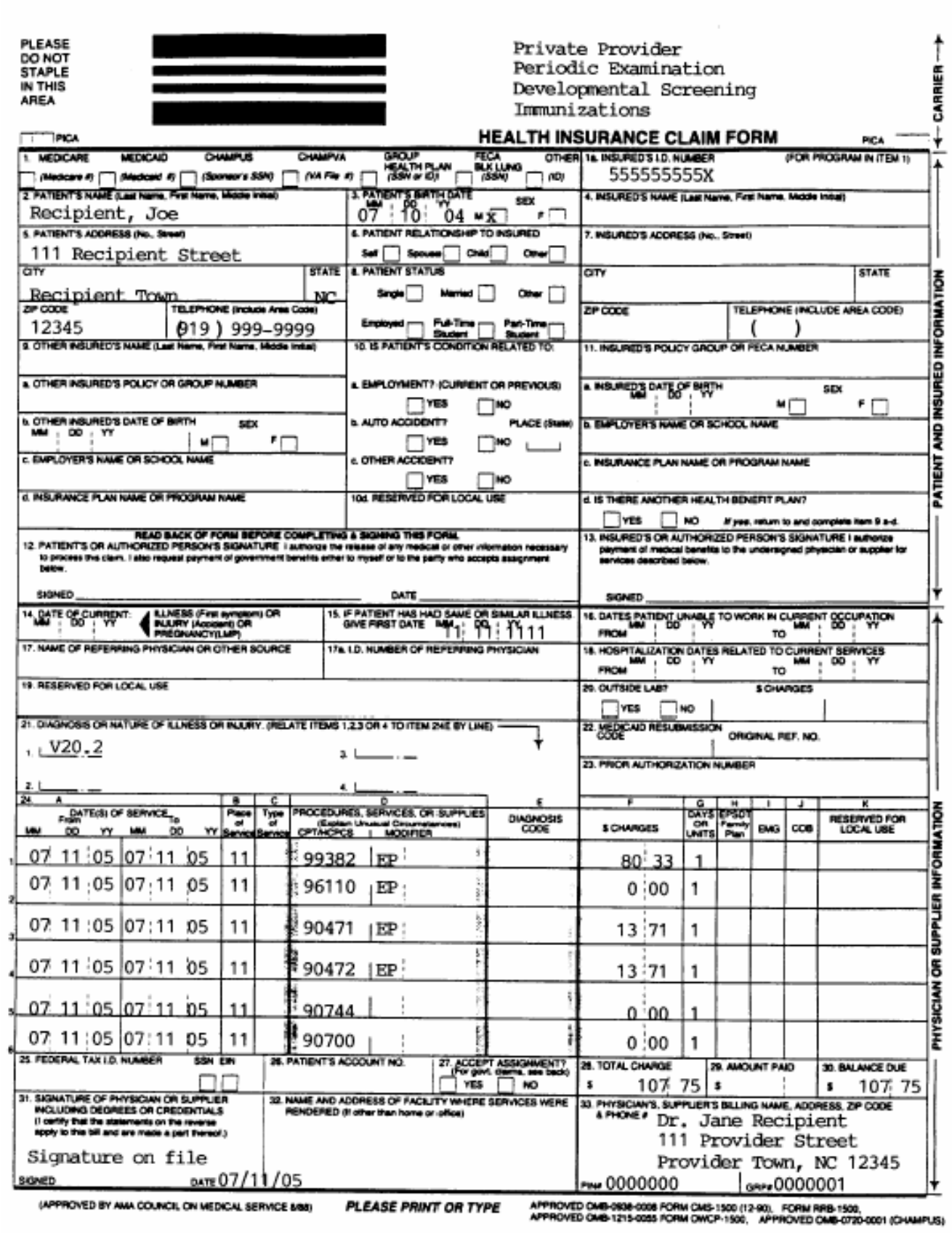
PIN# 0000000 GRP# 0000001

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

(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-0915-0064 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Periodic Examination
Developmental Screening
Immunizations

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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): 555555555X

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 10 04 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): (919) 999-9999

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: 11 11 1111

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

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. V20.2 3. 2. 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
1. 07 11 05 07 11 05	11		99382	EP		80 33	1				
2. 07 11 05 07 11 05	11		96110	EP		0 00	1				
3. 07 11 05 07 11 05	11		90471	EP		13 71	1				
4. 07 11 05 07 11 05	11		90472	EP		13 71	1				
5. 07 11 05 07 11 05	11		90744			0 00	1				
6. 07 11 05 07 11 05	11		90700			0 00	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 $ 107 75

29. AMOUNT PAID $

30. BALANCE DUE $ 107 75

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 07/11/05

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 Recipient
111 Provider Street
Provider Town, NC 12345

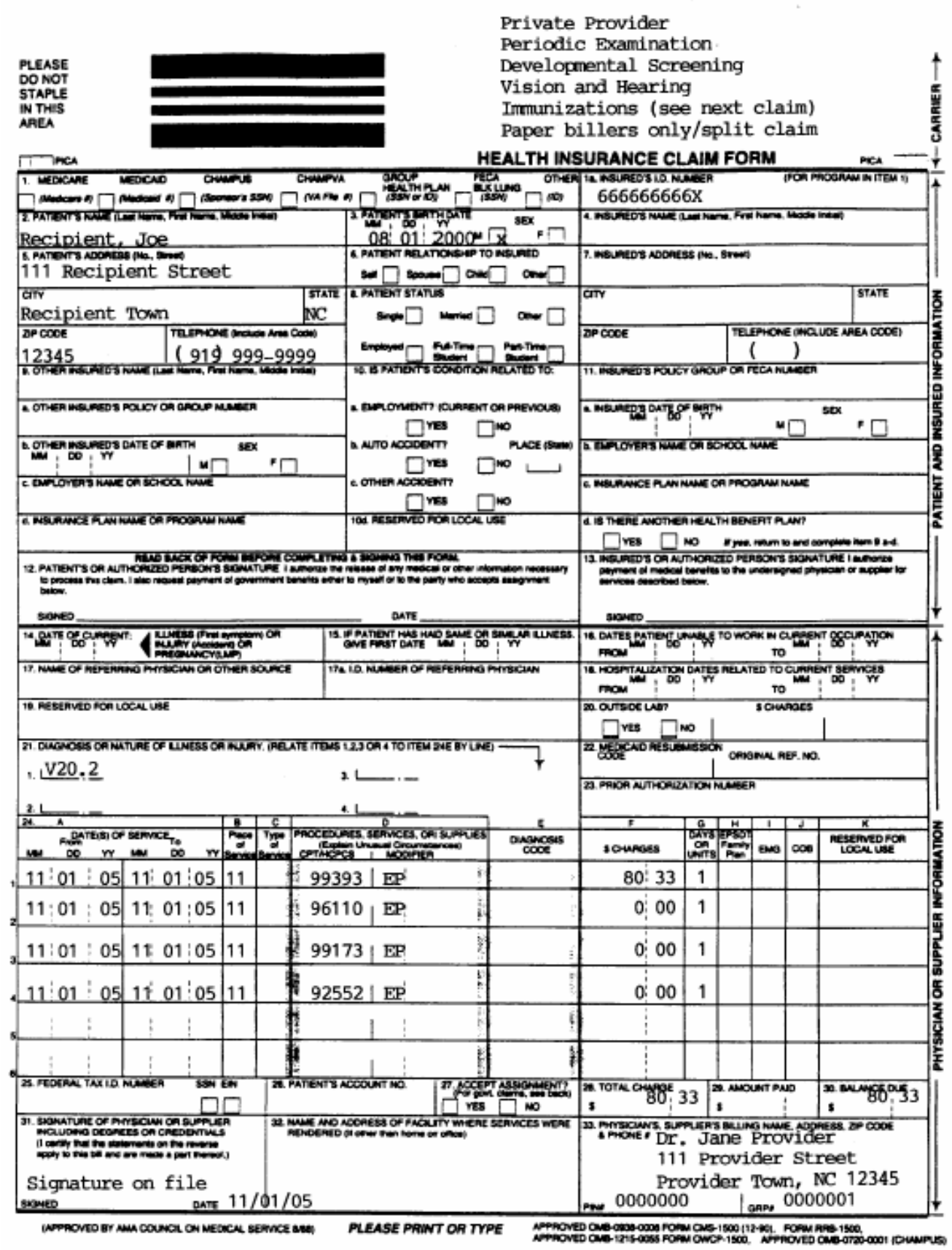
PIN# 0000000 GRP# 0000001

PATIENT AND INSURED INFORMATION — CARRIER

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)



Private Provider
Periodic Examination
Developmental Screening
Vision and Hearing
Immunizations (see next claim)
Paper billers only/split claim

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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): 666666666X

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 2000 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): (919) 999-9999

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

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

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. V20.2 3. 2. 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
1 11 01 05	11 01 05	11		99393	EP		80 33	1				
2 11 01 05	11 01 05	11		96110	EP		0 00	1				
3 11 01 05	11 01 05	11		99173	EP		0 00	1				
4 11 01 05	11 01 05	11		92552	EP		0 00	1				
5												
6												

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 $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

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 11/01/05

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 Provider Street
Provider Town, NC 12345

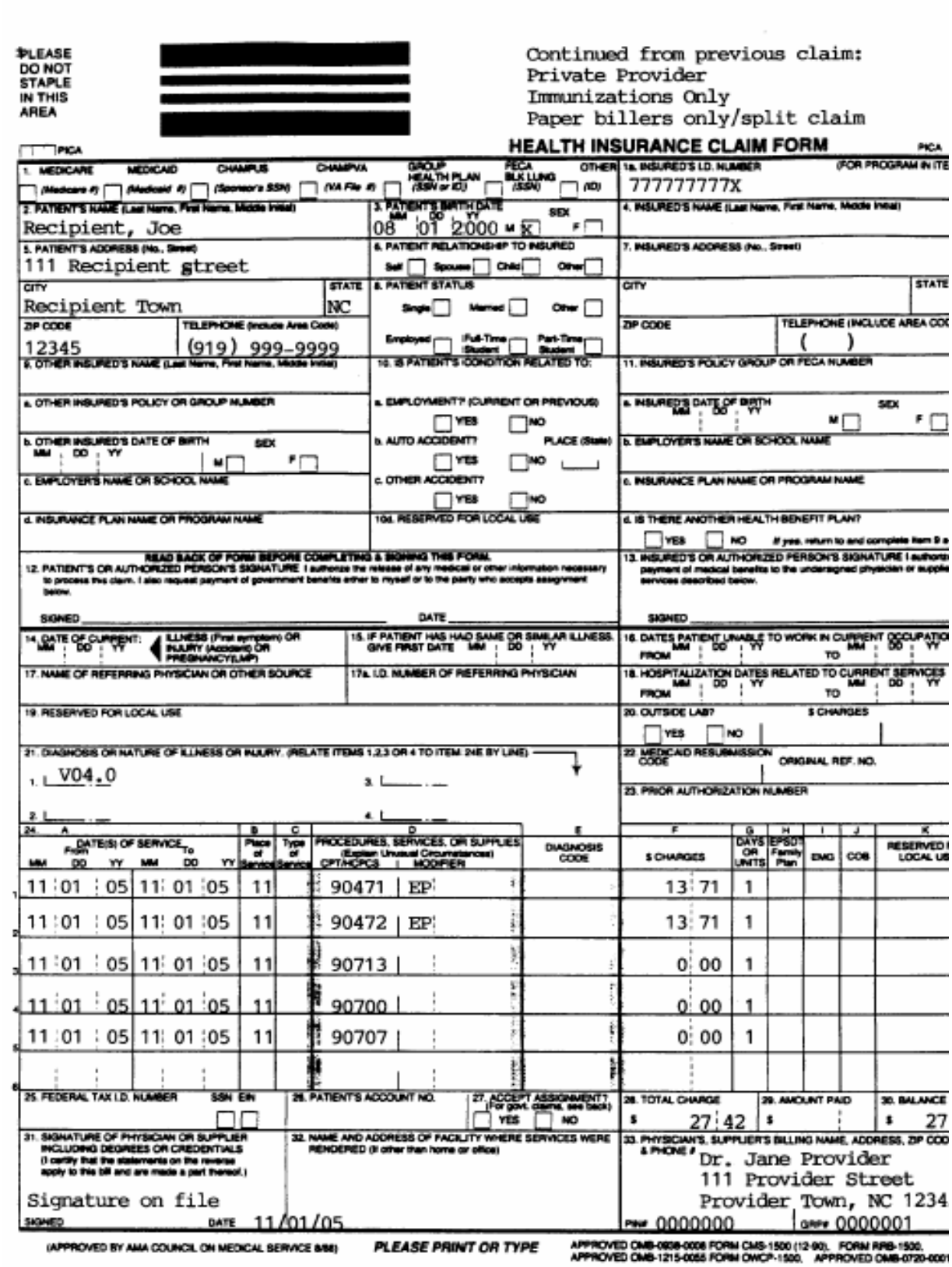
PIN# 0000000 GRP# 0000001

PATIENT AND INSURED INFORMATION

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)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Continued from previous claim:
Private Provider
Immunizations Only
Paper billers only/split claim

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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 ITE): 777777777X

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 2000 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): (919) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA COD): ( )

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

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 authoriz payment of medical benefits to the undersigned physician or supplie 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 OCCUPATIO MM DD YY FROM 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 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. V04.0
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 LOCAL USE
1 11 01 05	11 01 05	11		90471	EP		13 71	1				
2 11 01 05	11 01 05	11		90472	EP		13 71	1				
3 11 01 05	11 01 05	11		90713			0 00	1				
4 11 01 05	11 01 05	11		90700			0 00	1				
5 11 01 05	11 01 05	11		90707			0 00	1				
6												

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 $ 27 42

29. AMOUNT PAID $

30. BALANCE $ 27

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 11/01/05

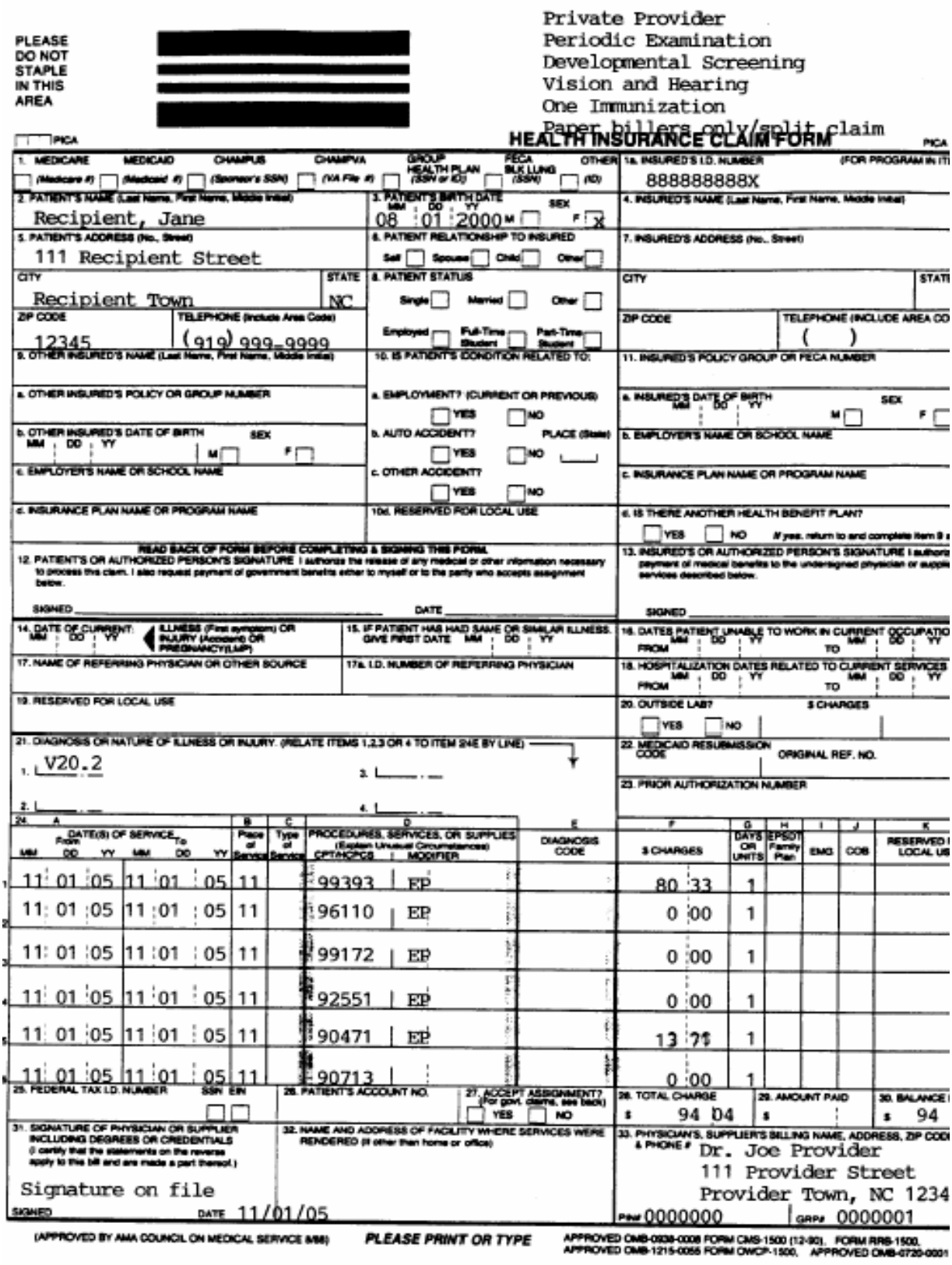
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Dr. Jane Provider
111 Provider Street
Provider Town, NC 1234

PIN# 0000000 GRP# 0000001

(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-0720-000



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Periodic Examination
Developmental Screening
Vision and Hearing
One Immunization
Paper billers only/split claim

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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): 888888888X

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 2000 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 [ ]

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CO): ( )

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

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

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

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. V20.2 3. 2. 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
1 11 01 05	11 01 05	11		99393	EP		80 33	1				
2 11 01 05	11 01 05	11		96110	EP		0 00	1				
3 11 01 05	11 01 05	11		99172	EP		0 00	1				
4 11 01 05	11 01 05	11		92551	EP		0 00	1				
5 11 01 05	11 01 05	11		90471	EP		13 71	1				
6 11 01 05	11 01 05	11		90713			0 00	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 $ 94 04

29. AMOUNT PAID $

30. BALANCE $ 94

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 11/01/05

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. Joe Provider
111 Provider Street
Provider Town, NC 1234

PIN# 0000000 GRP# 0000001

(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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Continued from previous claim:
Private Provider
Immunizations only

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | 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 ITE): 999999999X

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

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 2000 | SEX: M ☐ 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): (919) 999-9999

ZIP CODE: | TELEPHONE (INCLUDE AREA COD): ( )

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-

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 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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. V04.0
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
1 11 01 05	11 01 05	11		90471	EP		0 00	1				
2 11 01 05	11 01 05	11		90472	EP		13 71	1				
3 11 01 05	11 01 05	11		90700			0 00	1				
4 11 01 05	11 01 05	11		90707			0 00	1				
5												
6												

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 $ 13 71

29. AMOUNT PAID $

30. BALANCE $ 13

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 11/01/05

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

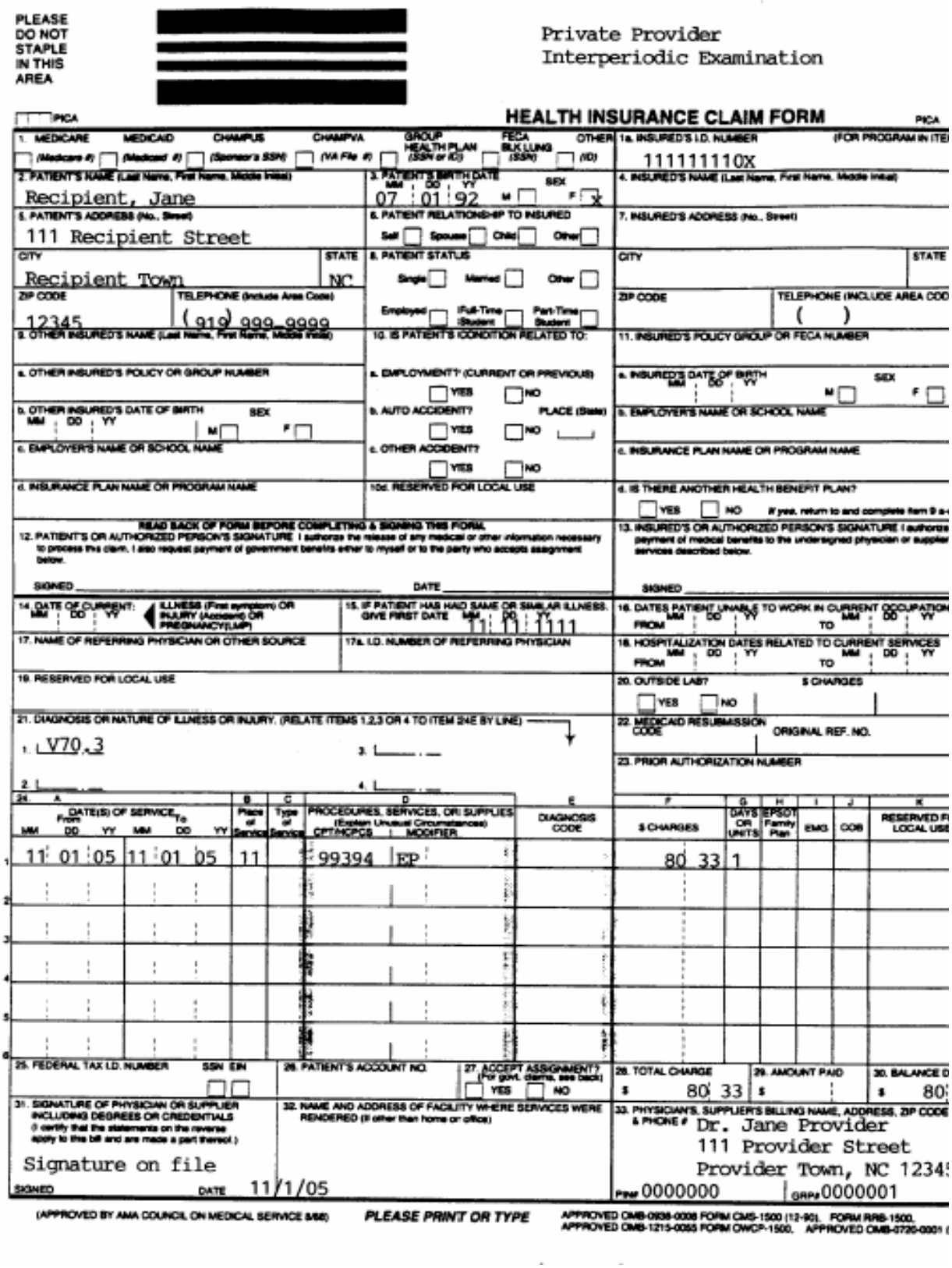
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 123

PIN# 0000000 GRP# 0000001

(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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Interperiodic Examination

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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: 111111110X

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

3. PATIENT'S BIRTH DATE: 07 01 92 SEX: M ☐ 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): (919) 999-9999

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 SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH 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-

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 11 11 1111

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. V70.3 3. 2. 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
1 11 01 05	11 01 05	11		99394	EP		80 33	1				
2												
3												
4												
5												
6												

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 $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80

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 11/1/05

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 Provider Street
Provider Town, NC 1234

PIN# 0000000 GRP# 0000001

(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 (

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Interperiodic Examination
Immunizations

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 111111111X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane	3. PATIENT'S BIRTH DATE: 02 07 2001 SEX: M ☐ F ☒
5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐
CITY: Recipient Town STATE: NC	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐
ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

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: 00 00 0000
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	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. V70.3 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
12 05 05	12 05 05	11		99382	EP		80 33	1				
12 05 05	12 05 05	11		90471	EP		13 71	1				
12 05 05	12 05 05	11		90472	EP		13 71	1				
12 05 05	12 05 05	11		90700			0 00	1				
12 05 05	12 05 05	11		90713			0 00	1				
12 05 05	12 05 05	11		90707			0 00	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 $ 107 75
29. AMOUNT PAID $	30. BALANCE $ 107		

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 12/05/05

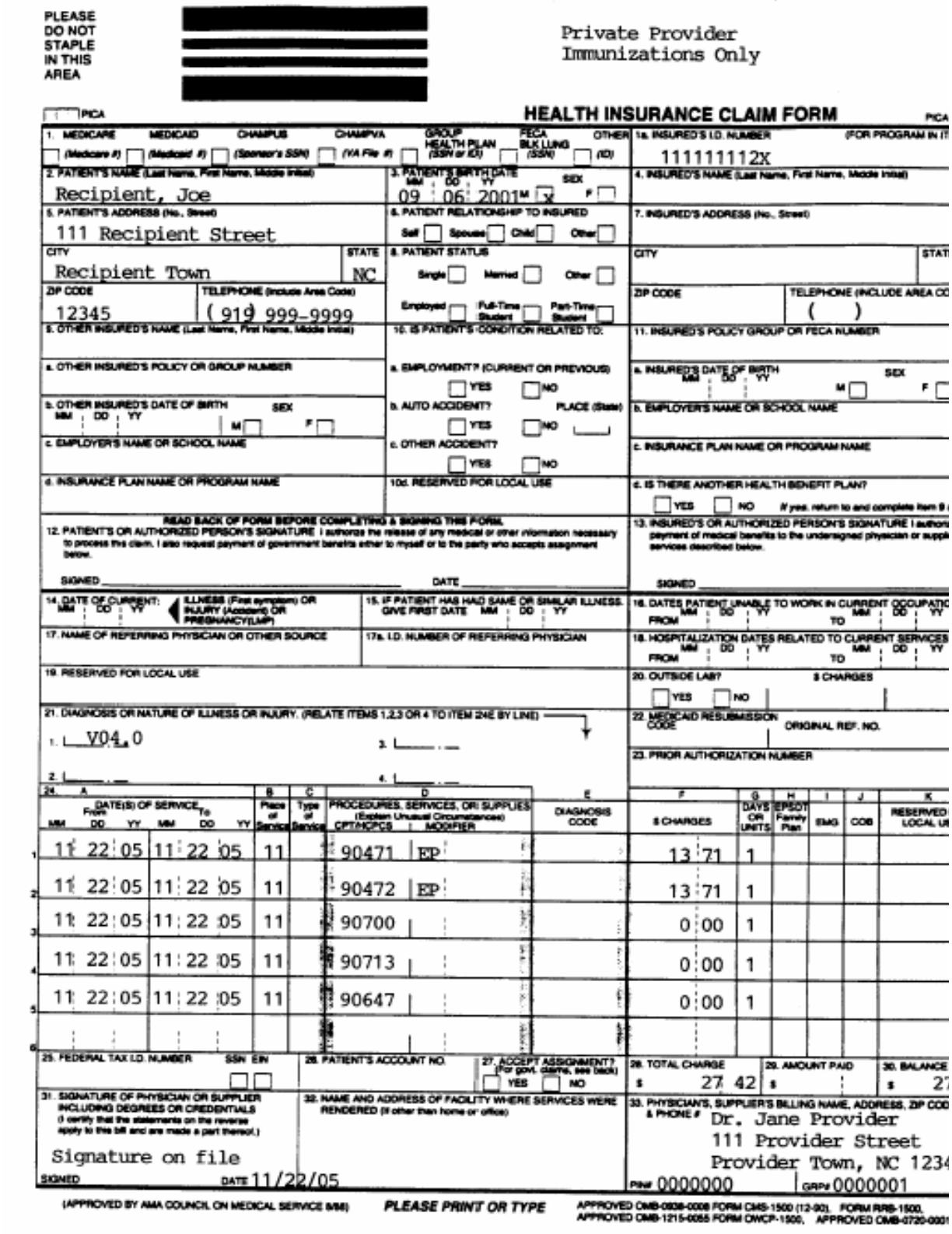
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Dr. Joe Provider
111 Provider Street
Provider Town, NC 123

PIN# 0000000 GRP# 0000001

(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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Immunizations Only

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) 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 I): 111111112X

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

3. PATIENT'S BIRTH DATE MM DD YY: 09 06 2001 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): (919) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CO): ( )

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

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 authori payment of medical benefits to the undersigned physician or suppl 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 OCCUPATIO 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

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. V04.0
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 LOCAL U
1 11 22 05	11 22 05	11		90471	EP		13 71	1				
2 11 22 05	11 22 05	11		90472	EP		13 71	1				
3 11 22 05	11 22 05	11		90700			0 00	1				
4 11 22 05	11 22 05	11		90713			0 00	1				
5 11 22 05	11 22 05	11		90647			0 00	1				
6												

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 $ 27 42

29. AMOUNT PAID $

30. BALANCE $ 27

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 11/22/05

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 COD & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town, NC 123

PIN# 0000000 GRP# 0000001

(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-0720-000

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Private Provider
Office Visit
Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN IT)
	111111113X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX
Recipient, Joe	06 11 2005 M X F
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
111 Recipient Street	Self / Spouse / Child / Other
CITY / STATE	8. PATIENT STATUS
Recipient Town / NC	Single / Married / Other
ZIP CODE / TELEPHONE (Include Area Code)	Employed / Full-Time Student / Part-Time Student
12345 / (919)999-9999	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M / F	b. AUTO ACCIDENT? YES / NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

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 _____

7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	
ZIP CODE / TELEPHONE (INCLUDE AREA CO)	( )
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY / SEX M / F	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a	

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authoriz payment of medical benefits to the undersigned physician or supplie 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 OCCUPATIO MM DD YY FROM / MM DD YY 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 / 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. 382.9 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
1 11 14 05	11 14 05	11		99212			47 50	1				
2 11 14 05	11 14 05	11		90471	EP		13 71	1				
3 11 14 05	11 14 05	11		90472	EP		13 71	1				
4 11 14 05	11 14 05	11		90713			0 00	1				
5 11 14 05	11 14 05	11		90707			0 00	1				
6												

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 $ 74 92
29. AMOUNT PAID $	30. BALANCE $ 74		
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 11/14/05	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 Provider Street Provider Town, NC 1234 PIN# 0000000 GRP# 0000001

(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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FQHC/RHC
Periodic Examination
Vision and Hearing

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	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 ITE
							111111117X		

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)
Recipient, Jane	11 14 1993 M ☐ F ☒	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
111 Recipient Street	Self ☐ Spouse ☐ Child ☐ Other ☐	
CITY: Recipient Town / STATE: NC	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE: 12345 / TELEPHONE (Include Area Code): (919) 999-9999	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA COD: ( )
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-

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 _____

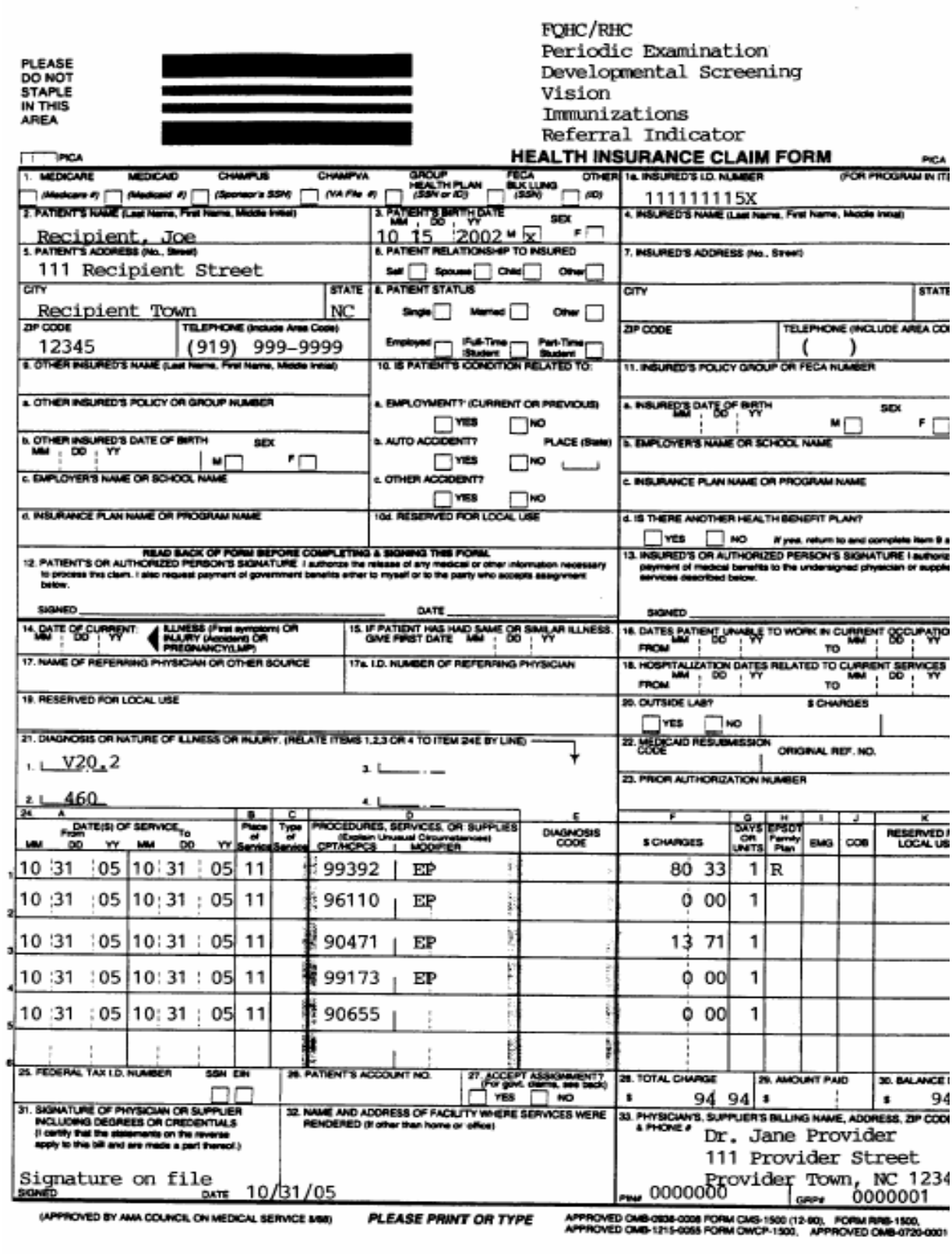
14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM / TO
19. RESERVED FOR LOCAL USE		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. V20.2 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
11 23 05	11 23 05	11		99394	EP		80 33	1				
11 23 05	11 23 05	11		99173	EP		0 00	1				
11 23 05	11 23 05	11		92551	EP		0 00	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 $ 80 33	29. AMOUNT PAID $	30. BALANCE D $ 80

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. 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 #
Signature on file		Dr. Joe Provider 111 Provider Street Provider Town, NC 12345
SIGNED DATE 11/23/05		PIN# 0000000 GRP# 100000C

(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 (



FQHC/RHC
Periodic Examination
Developmental Screening
Vision
Immunizations
Referral Indicator

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 111111115X
2. PATIENT'S NAME: Recipient, Joe	3. PATIENT'S BIRTH DATE: 10 15 2002 SEX: M x F
5. PATIENT'S ADDRESS: 111 Recipient Street	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
CITY: Recipient Town STATE: NC	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student
ZIP CODE: 12345 TELEPHONE: (919) 999-9999	
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? YES / NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

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 authoriz payment of medical benefits to the undersigned physician or supplie 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
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATIO 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. V20.2 2. 460 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
1 10 31 05	10 31 05	11		99392	EP		80 33	1	R			
2 10 31 05	10 31 05	11		96110	EP		0 00	1				
3 10 31 05	10 31 05	11		90471	EP		13 71	1				
4 10 31 05	10 31 05	11		99173	EP		0 00	1				
5 10 31 05	10 31 05	11		90655			0 00	1				
6												

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 $ 94 94
29. AMOUNT PAID $	30. BALANCE $ 94		

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 10/31/05

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 Provider Street
Provider Town, NC 1234
PIN# 0000000 GRP# 0000001

(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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FQHC/RHC
Interperiodic Examination

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITE: 111111116X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe	3. PATIENT'S BIRTH DATE: 06 11 1987 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 [ ]
CITY — STATE	
ZIP CODE: 12345 — TELEPHONE (Include Area Code): (919) 999-9999	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE — TELEPHONE (INCLUDE AREA COD: ( )	
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-	

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 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	
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	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. V70.3 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
1 12 16 05 — 12 16 05	11		99395	EP		80 33	1				
2											
3											
4											
5											
6											

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 $ 80 33 — 29. AMOUNT PAID $ — 30. BALANCE D $ 80
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 12/16/05	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 Provider Street Provider Town, NC 1234 PIN# 0000000 GRP# 0000001

(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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FQHC/RHC
Periodic Examination
Vision and Hearing

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER		1a. INSURED'S I.D. NUMBER	111111117X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Recipient, Jane	3. PATIENT'S BIRTH DATE / SEX	11 14 1993 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		
CITY		STAT	
ZIP CODE	12345	TELEPHONE (Include Area Code)	(919)999-9999
	Employed / Full-Time Student / Part-Time Student		
ZIP CODE		TELEPHONE (INCLUDE AREA CO	( )
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 / SEX
b. OTHER INSURED'S DATE OF BIRTH / 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

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 authori payment of medical benefits to the undersigned physician or suppl services described below.

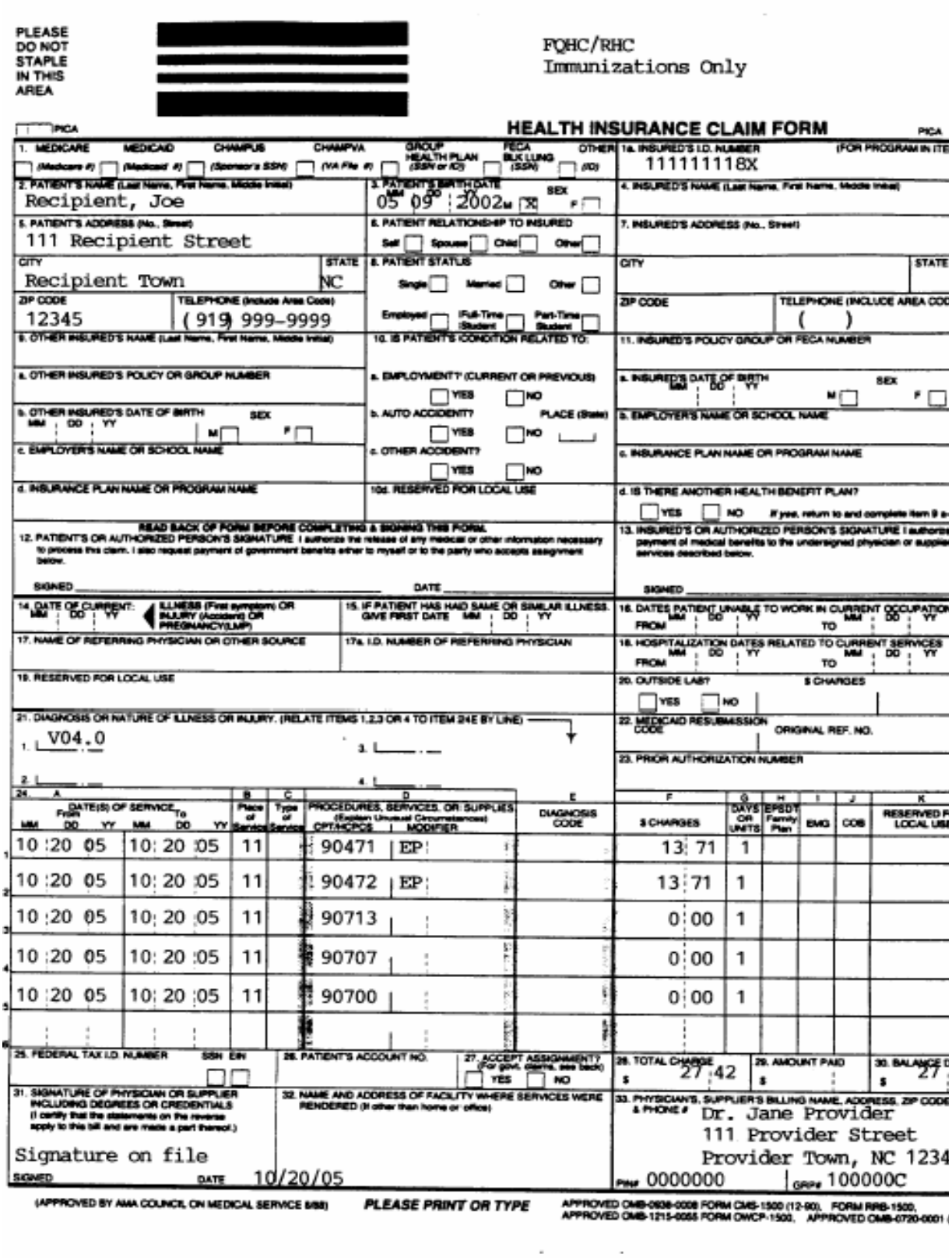
SIGNED _____

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	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATI
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. V20.2 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 LOCAL U
1 11 23 05	11 23 05	11		99394	EP		80 33	1				
2 11 23 05	11 23 05	11		99173	EP		0 00	1				
3 11 23 05	11 23 05	11		92551	EP		0 00	1				
4												
5												
6												

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 $ 80 33	29. AMOUNT PAID $	30. BALANCE $ 80
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.) Signature on file SIGNED DATE 11/23/05	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 COD & PHONE # Dr. Joe Provider 111 Provider Street Provider Town, NC 123 PIN# 0000000 GRP# 100000C		

(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-0720-000



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FQHC/RHC
Immunizations Only

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITE)
	111111118X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX
Recipient, Joe	05 09 2002 M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
111 Recipient Street	Self [ ] Spouse [ ] Child [ ] Other [ ]
CITY / STATE	8. PATIENT STATUS
Recipient Town / NC	Single [ ] Married [ ] Other [ ]
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
12345 / (919) 999-9999	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

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 _____

11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH SEX	M [ ] F [ ]
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a	

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
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)	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. V04.0 3.	23. PRIOR AUTHORIZATION NUMBER
2. 4.	

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
1 10 20 05	10 20 05	11		90471	EP		13 71	1				
2 10 20 05	10 20 05	11		90472	EP		13 71	1				
3 10 20 05	10 20 05	11		90713			0 00	1				
4 10 20 05	10 20 05	11		90707			0 00	1				
5 10 20 05	10 20 05	11		90700			0 00	1				
6												

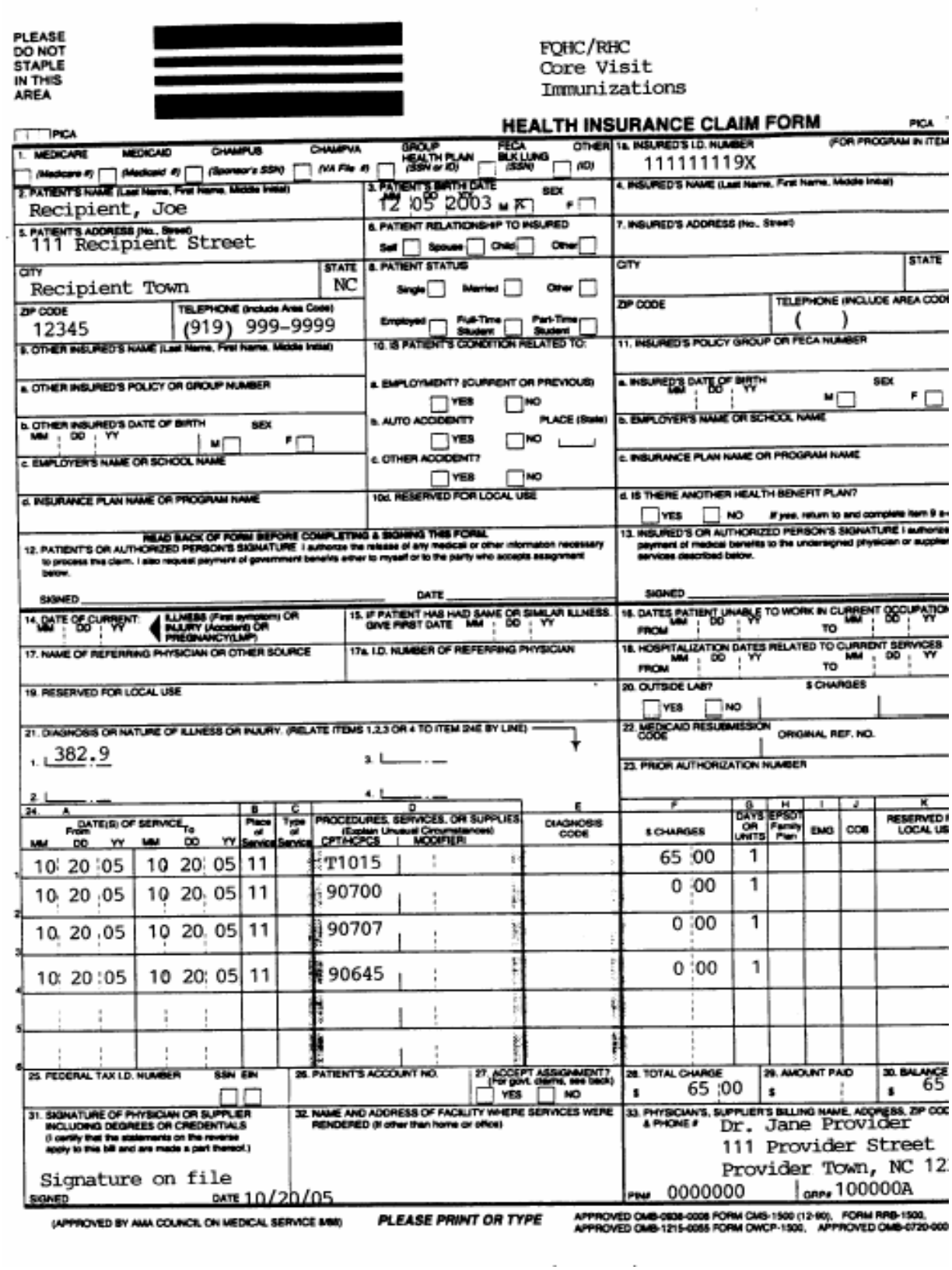
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ 27 42
29. AMOUNT PAID $	30. BALANCE D $ 27		

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Signature on file	
SIGNED DATE 10/20/05	

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

Dr. Jane Provider
111 Provider Street
Provider Town, NC 1234
PIN# 0000000 GRP# 100000C

(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



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FQHC/RHC
Core Visit
Immunizations

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 111111119X
2. PATIENT'S NAME: Recipient, Joe	3. PATIENT'S BIRTH DATE: 12 05 2003 SEX: M X F
5. PATIENT'S ADDRESS: 111 Recipient Street	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
CITY: Recipient Town STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
ZIP CODE: 12345 TELEPHONE: (919) 999-9999	
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? YES NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

4. INSURED'S NAME	
7. INSURED'S ADDRESS	
CITY / STATE	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE)	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH SEX	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO	

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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

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. 382.9
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
10 20 05	10 20 05	11		T1015			65 00	1				
10 20 05	10 20 05	11		90700			0 00	1				
10 20 05	10 20 05	11		90707			0 00	1				
10 20 05	10 20 05	11		90645			0 00	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 $ 65 00

29. AMOUNT PAID $

30. BALANCE $ 65

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 10/20/05

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 Provider Street
Provider Town, NC 12
PIN# 0000000 GRP# 100000A

(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-0720-000

N.C. Health Services Information System Screen Examples

Following are screen entry examples of the services screen (Option 65) for local health departments that use the N.C. Health Services Information System (HSIS)

Example #1 – Health Check Periodic Examination
Six-month-old child
Developmental screening
Immunizations

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 222222222   DATE 071004   ACTION A
MESSAGE:

NAME: Brown, Charlie                                DATE OF DIAB EVAL:______
SERVICE GROUP:
DIAG CODES A: V20.2 B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99381  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  96110  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  90700  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  90713  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
```

Example #2 – Health Check Periodic Examination
18-year-old
Vision screening
Hearing screening
Diagnosis warrants a referral for a follow-up visit
Designated with "ST/S2"

```
NEXT RECORD:  COUNTY 999    SCREEN 65    ID 333333333   DATE 070904  ACTION A
MESSAGE:

NAME: Patty, Peppermint                             DATE OF DIAB EVAL:______
SERVICE GROUP:
DIAG CODES A: V20.2 B: 460.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.___
           H: ___.__
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99385  EP ST S2  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  99173  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  92552  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 B  CH  87081  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____   _  99999
```

N.C. Health Services Information System Screen Examples, continued

Example #3 – Health Check Periodic Examination
4-year-old child
Developmental screening
Vision screening
Hearing Screening

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID 444444444    DATE 120904  ACTION A
MESSAGE:

NAME: Smith, Barbie                                  DATE OF DIAB EVAL: ______
SERVICE GROUP:
DIAG CODES A: V20.2 B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99392  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  96110  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  99172  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  92587  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example #4 – Health Check Periodic Examination
1-year-old child
Developmental screening

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 444444444    DATE 120904  ACTION A
MESSAGE:

NAME:  Robin, Christopher                            DATE OF DIAB EVAL: ______
SERVICE GROUP:
DIAG CODES A: V20.2 B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99392  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  96110  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #5 – Immunization Administration Fee ONLY for Child Age 3

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 555555555    DATE 112204   ACTION A
MESSAGE

NAME: Barkley, Charles                              DATE OF DIAB EVAL: ______
SERVICE GROUP:
DIAG CODES A: V06.8 B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  IM  90471  EP __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  IM  90700  __ __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  IM  90713  __ __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  IM  90744  __ __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  IM  90647  __ __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
```

Example #6 – Office Visit with One Immunization for a Child Age 2

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 666666666    DATE 111404   ACTION A
MESSAGE

NAME: Smith, Hercules                             DATE OF DIAB EVAL:______
SERVICE GROUP:                                          THRU DT: ______
DIAG CODES A: 382.9  B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99212  __ __ __  A _ _ _  PHY    01   71  _____  __  _____  _   99999
 B  CH  90471  EP __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
 R  CH  90716  __ __ __  A _ _ _  NURSE  01   71  _____  __  _____  _   99999
```

Policy Statement

Pediatrics **Volume 108, Number 1** **July 2001, pp 192-196**

Developmental Surveillance and Screening of Infants and Young Children (RE0062)

AMERICAN ACADEMY OF PEDIATRICS
Committee on Children with Disabilities

RECOMMENDATIONS

All infants and young children should be screened for developmental delays. Screening procedures should be incorporated into the ongoing health care of the child as part of the provision of a medical home, as defined by the Academy.[51] to screen for developmental delays or disabilities and intervene with the identified children and their families, the primary pediatrician providing the medical home should:

1. Maintain and update her or his knowledge about developmental issues, risk factors, screening techniques, and community resources, such as early intervention, school, Title V, and other community-based programs, for consultation, referral, and intervention.
2. Acquire skills in the administration and interpretation of reliable and valid developmental screening techniques appropriate for the population.
3. Develop a strategy to provide periodic screening in the context of office-based primary care, including the following:
   - Recognizing abnormal appearance and function during health care maintenance examinations;
   - Recognizing medical, genetic, and environmental risk factors while taking routine medical, family, and social histories;
   - Listening carefully to parental concerns and observations about the child's development during all encounters;
   - Recognizing troubled parent-child interaction by reviewing history or by observation;
   - Performing periodic screenings of all infants and young children during preventive care visits; and
   - Recognizing the importance that test procedures and processes be culturally sensitive and appropriate to the population.
4. Present the results of the screening to the family using a culturally sensitive, family-centered approach.
5. With parental agreement, refer children with developmental delays in a timely fashion to the appropriate early intervention and early childhood education programs and other community-based programs serving infants and young children.
6. Determine the cause of delays or refer to appropriate consultant for determination. Screen hearing and vision to rule out sensory impairments.
7. Maintain links with community-based resources, such as early intervention, school, and other community-based programs, and coordinate care with them.
8. Increase parents' awareness of developmental disabilities and resources for intervention by such methods as display and distribution of educational materials in the office.
9. Be available to families to interpret consultants' findings.

Ongoing involvement with the family permits the pediatrician to respond to parental concerns about the child's development when such concerns exist. When parents are not aware that a delay exists, the pediatrician can guide them toward closer observation of the child and, thus, enable them to recognize the delay. Referral for evaluation and services can take place only after the pediatrician has succeeded in this challenging task. At that point, the pediatrician's role shifts to one of involvement in the evaluation as appropriate, referral to available community resources for intervention and family support, assistance in understanding the evaluation results, assessment and coordination of services, and monitoring the child's developmental progress as part of the provision of a medical home.

CONCLUSION

Early identification of children with developmental delays or disabilities can lead to treatment of, or intervention for, a disability and lessen its impact on the functioning of the child and family. Because developmental screening is a process that selects children who will receive more intensive evaluation or treatment, all infants and children should be screened for developmental delays. Developmental surveillance is an important method of detecting delays. Moreover, the use of standardized developmental screening tools at periodic intervals will increase accuracy. Pediatricians should consider using standardized developmental screening tools that are practical and easy to use in the office setting. Successful early identification of developmental disabilities requires the pediatrician to be skilled in the use of screening techniques, actively seek parental concerns about development, and create links with available resources in the community.

Please Note: The recommendations and conclusions stated above are part of the AAP Policy Statement on Developmental Surveillance and Screening of Infants and Young Children (RE0062) Volume 108, Number 1, July 2001 pp 192-196. The entire policy can be found on their website at http://aappolicy.aappublications.org.

TIPS FOR DECREASING DENIALS

EOB	Message	Tip
010	Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.	Verify the recipient's Medicaid identification (MID) number, date of birth (DOB), diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2519 Mail Service Center, Raleigh, NC 27699-2519.
060	Not in accordance with medical policy guidelines.	Verify that only one vision and/or hearing screening assessment is billed per date of service. Make corrections and resubmit as a new day claim.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.	Verify diagnosis code is V20.2 or V70.3 for the Health Check screening examination according to the billing guidelines on page 9. Correct claim and resubmit.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient's age. Only recipients age birth through 20 years of age are eligible for Health Check program services.
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Immunizations(s) are available at no charge through the UCVDP/VFC Program.
1058	The only well child exam billable through the Medicaid program is a Health Check screening examination. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic screening examination with V20.2 and interperiodic screenings examinations with V70.3. Check the preventive medicine code entered in block 24D of the claim form.
1422	Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check special bulletin.	Check the claim to ensure that the immunization procedure code(s) are billed on the same claim as the immunization administration code(s). Make corrections and resubmit as a new day claim.
1769	No additional payment made for vision, hearing and/or developmental screening services.	Payment is included in Health Check reimbursement.
1770	Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	Health Check services must be billed with the diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V250.9.

1771	All components were not rendered for this Health Check screening examination.	For periodic screenings examinations, verify all required components, such as vision and/or hearing assessments were performed and reported on the claim form using the EP modifier. Make corrections and resubmit as a new day claim.

HEALTH CHECK WORKSHEETS

Health Check Billing Worksheet

The Health Check Billing Worksheet (see page 44) may be used in your practice to facilitate Health Check billing.

For additional billing questions please contact EDS at 1-800-688-6696 or 919-851-8888.

Health Check Immunization Worksheet

The Immunization Billing Worksheet (see page 45) may be used in your practice to as a guide to billing for immunizations provided to Health Check recipients.

HEALTH CHECK BILLING WORKSHEET

Date of Service _____

Patient's Name	Next Screening Date (optional)
Medicaid ID number	Date of Birth

Health Check Diagnosis Code		
Periodic Health Check Examination	Periodic Health Check Examination V20.2	
Interperiodic Health Check Examination	Interperiodic Health Check Examination V70.3	

Health Check Screening Code			
Description	**Preventive Medicine Codes**	**Diagnosis Code**	✓
Regular Periodic Examination - Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V20.2	
Developmental Screening based on age	Development Screening CPT Code 96110 With EP Modifier		
Vision Assessment based on age	Vision Assessment CPT Code 99172 or 99173 With EP Modifier		
Hearing Assessment based on age	Hearing Assessment CPT Code 92551, 92552 or 92587 With EP Modifier		
Interperiodic Examination - Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V70.3	

Second Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with screening provider or another provider	R; providers billing on paper	
Third Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with screening provider or another provider	R; providers billing on paper	
Fourth Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with screening provider or another provider	R; providers billing on paper	

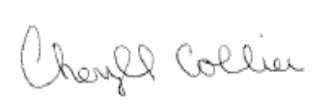
Description	**CPT Codes**	**Unit**	
Immunization Administration Fee	90471 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 EP Modifier	Additional immunizations	

IMMUNIZATION BILLING WORKSHEET

Code	Description	Diagnosis	VFC
90281	Immune Globulin	V07.2	
90371	Hepatitis B Immune Globulin	V07.2	
90375	Rabies Immune Globulin	V07.2	
90376	Rabies Immune Globulin – Heat treated (RIG-HT)	V07.2	
90384	Rho (D) Immune Globulin Full Dose	V07.2	
90385	Rho (D) Immune Globulin Mini Dose	V07.2	
90389	Tetanus Immune Globulin	V07.2	
90396	Varicella-Zoster Immune Globulin	V07.2	
90585	BCG	V03.2	
90632	Hepatitis A Vaccine – Age 18 & up	V05.8	
90633	Hepatitis A Vaccine – 2 dose Age 2 & up	V05.8	
90645	Hib Titer – 4 dose	V03.8 or V05.8	VFC 2 mo – 5 yrs
90648	Hib – 4 dose (Brand name – ActHib)	V03.8 or V05.8	VFC 2 mo – 5 yrs
90655	Influenza, split virus, preservative free (6-35 months of age)	V04.8	VFC 6 mo – 35 mo
90657	Influenza, split virus (6 to 35 months of age)	V04.8	VFC 6 mo – 35 mo
90658	Influenza, split virus (Age 3 and up)	V04.8	VFC 3 yrs – 18 yrs
90669	Pneumococcal PCV7 (2-59 months)	V03.82 or V05.8	VFC 2 mo – 59 mo
90675	Rabies Vaccine – IM	V04.5	
90700	DTaP	V06.8	VFC 2 mo – 7 yrs
90702	DT – Age under 7	V06.8	VFC 2 mo – 6 yrs
90703	Tetanus Toxoid	V03.7	
90704	Mumps	V04.6	
90705	Measles	V04.2	
90706	Rubella	V04.3	
90707	MMR	V06.4	VFC 12 mo – 18 yrs
90713	IPV (Injectable Polio Vaccine)	V04.0	VFC 2 mo – 18 yrs
90716	Varicella	V05.4	VFC 12 mo – 18 yrs
90718	Td	V06.5	VFC 7 yrs – 18 yrs
90721	DTaP/Hib	V06.8	
90723	Pediarix	V06.8	
90732	Pneumococcal PPV23	V03.82 or V05.8	VFC 2 yrs – 18 yrs
90733	Meningococcal	V03.89	
90744	Hepatitis B Vaccine – Pediatric/adol -3 dose	V05.8	VFC 0 – 18 yrs
90746	Hepatitis B Vaccine – Age 19 and above	V05.8	
90747	Hepatitis B Vaccine - Dialysis Pt./immunosuppressed -4 dose	585	

Note: This list is subject to change. Updates regarding vaccines are published in the general Medicaid bulletins on DMA's web site at http://dhhs.state.nc.us/dma/bulletin.htm.

Mark T. Benton, Interim Director
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS