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Attention: All Health Check Providers

Effective July 1, 2006

Health Check Billing Guide 2006

Providers are responsible for informing their billing agency of information in this bulletin.
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Effective with date of service July 1, 2006, please replace the April 2005 Special Bulletin III, *Health Check Billing Guide 2005*, with this special bulletin. For your convenience key words and phrases have been bolded or highlighted.

Introduction

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or Medicaid for children is administered under the name **Health Check** in North Carolina. EPSDT is defined by federal law and includes periodic screening, vision, dental, and hearing services. In addition, section 1905 (a) of the Social Security Act (the Act) requires that any medically necessary health care service to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening listed in section 1905 (a) of the Act be provided to a Medicaid recipient under age 21 even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population.

EPSDT may cover some services that are not covered for recipients aged 21 and older. Services must be ordered by the recipient's physician or other licensed clinician. The services cannot be experimental/investigational, unsafe, or ineffective. Prior Approval from the Division of Medical Assistance (DMA) may be required for some services or procedures before they can be provided. If approval is denied or services are reduced or terminated, the recipient or his/her representative can appeal the decision. Instructions for requesting prior approval for covered and non-covered N.C. State Medicaid Plan services can be found on page 14 of this guide.

Note: Prior Approval still applies for services currently requiring Prior Approval. Information regarding Prior Approval can be found on page 14 of this guide.

For additional information about EPSDT refer to the North Carolina Medicaid Special Bulletin, December 2005, Medicaid for Children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Health Check at **http://www.dhhs.state.nc.us/dma/bulletin/EPSDT.pdf**. **Policy Instructions: Early and Periodic Screening, Diagnostic and Treatment including** a list of Federal Medicaid Covered Services can also be found at **http://www.dhhs.state.nc.us/dma/epsdt_policy.pdf.**

Health Check Overview

Health Check or EPSDT is important because it:

1. Provides early and regular medical and dental screenings for all Medicaid recipients under the age of 21.
2. Is part of the Federal Medicaid EPSDT requirement that provides recipients with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

Health Check examinations and other Medicaid covered services are free of charge to the recipient. Health Check recommends regular medical screening examinations (well child check-ups) for a recipient as indicated in the table below. **This Periodicity Schedule is only a guideline, and, if a recipient needs to have examinations on a different schedule, the visits are still covered.**

Periodicity Schedule

Within 1st month	9 or 15 months	3 years	9 years
2 months	12 months	4 years	12 years
4 months	18 months	5 years	15 years
6 months	2 years	6 years	18 years

Each **Health Check** screening component is vital for measuring a child's physical, mental, and developmental growth**.** Families are encouraged to have their children receive Health Check screening examinations and immunizations on a regular schedule. All Health Check components are required and must be documented in the child's medical record. The components are based on the The American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* and may be found at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/3/645.

In addition, it is also the responsibility of each health care provider to assist families in scheduling appointments for timely examinations, to create a quality system to follow-up with families whose children are delinquent for preventive health care examinations, and to make appropriate referrals and requests for medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

Periodic and Interperiodic Health Check Visits

Periodic Health Check examinations require all age appropriate components including developmental screening, vision screening, hearing screening, and immunizations as needed. Refer to the Periodicity Schedule on page 1 of this guide for recommended age intervals for periodic examinations.

Interperiodic Health Check examinations require all age appropriate components **except developmental, hearing, and vision screenings** and **may be performed outside of the recommended Periodicity Schedule on page 1 of this guide for reasons including but not limited to :**

- When a child requires a kindergarten or sports physical outside the recommended schedule.
- When a child's previously diagnosed physical, mental, or developmental illnesses or conditions require closer monitoring.
- When further assessment, diagnosis, or treatment is needed due to physical or mental illness.
- Upon referral by a health, developmental, or educational professional based on physical or clinical assessment.

Note: Providers must document in the medical record the reason necessitating an interperiodic examination.

Health Check Examination Components

A complete Health Check examination consists of the following age-appropriate components.

- **Comprehensive unclothed physical examination**
  To be performed at every Health Check examination.

- **Comprehensive health history**
  To be performed at every Health Check examination.

- **Nutritional assessment**
  To be performed at every Health Check examination.

- **Anticipatory guidance and health education**
  To be performed at every Health Check examination.

- **Measurements, blood pressure, and vital signs**
  To be performed as age appropriate and medically necessary at every Health Check examination. 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**
  To be performed at Periodic examinations at ages 6 , 12, and 18 or 24 months, and 3 years, four years, and five years of age using a standardized and validated screening tool. A complete list of appropriate screening tools can be found at www.dbpeds.org/. The American Academy of Pediatric's policy on Developmental Surveillence and Screening can be found at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/192.

- **Immunizations**
  Immunizations must be provided at the time of a Periodic or Interperiodic examination if needed. **It is not appropriate for a Health Check examination to be performed in one location and a child referred to another location or office for immunizations**. The *Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2006*, 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/preview/mmwrhtml/mm5451-Immunizationa1.htm.

  Note: Please refer to pages 9-13 and 24 in this guide for additional immunization information.

- **Vision screenings**
  Objective screenings must be performed during **every** periodic examination beginning at age 3.
  For children who are uncooperative with a vision screening, providers may ask the parent or legal guardian to bring the child back into the office within a few days for a second attempt at the vision screening.

- **Hearing screenings**
  Objective screenings must be performed during **every** periodic examination beginning at age 4.
  For children who are uncooperative with a hearing screening, providers may ask the parent or legal guardian to bring the child back into the office within a few days for a second attempt at the hearing screening.

Health Check Examination Components, continued

Note: 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.

- **Dental screenings**

  An oral screening is to be performed at every Health Check examination**. In addition, referral to a dentist is required for every child by the age of 3 years old.** 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 cares), 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 examinations.

Note: Although not a requirement of a Health Check examination, providers performing a Health Check examination may bill for dental varnishing and receive reimbursement in addition to a Health Check examination. Refer to the August 2002 general Medicaid Bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin/0802bulletin1.htm for billing codes and guidelines.

- **Laboratory procedures**

Laboratory procedures include Hemoglobin or Hematocrit, Urinalysis, Sickle Cell, Tuberculin Skin Test, and Lead Testing.

Note: Medicaid will not reimburse separately for these routine 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 there is a documented normal result of a hemoglobin or hematocrit preformed by another provider within three months prior to the date of the Health Check examination, repeating the hemoglobin or hematocrit is not required as part of the Health Check examination 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 requirements and time frames, call the local WIC office.

Health Check Examination Components, continued

Urinalysis

Urinalysis **must** be performed during the 5 year old Periodic examination as well as during

Periodic examinations for all sexually active males and females.

Sickle Cell

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 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 (TB)

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 testing is indicated. **If none of the screening criteria listed below are present, there is no recommendation for routine TB screening.**

TB 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.

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

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.

Health Check Examination Components, continued

- **Lead testing**

  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 must be tested if they have not been previously tested. Providers should also perform lead testing when otherwise 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 testing. 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 of age 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 Testing

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 should to contact the State Laboratory of Public Health at 919-733-3937.

For additional information about lead testing and follow up refer to the North Carolina Lead Screening and Follow up Manual found at http://www.deh.enr.state.nc.us/ehs/Children_Health/printedversionleadmanual.pdf.

IMMUNIZATIONS

Immunization Administration CPT Codes 90471 and 90472 or 90465 and 90466 with the EP Modifier

Medicaid reimburses providers for the administration of immunizations to Medicaid-enrolled children, birth through 20 years of age, as specified below. **Always use the EP modifier when billing 90471 and 90472 or 90465 and 90466.**

Note: Immunization administration CPT codes 90465 and 90466 must be used when the recipient is less than 8 years of age and is counseled by a physician. Refer to the July 2005 general Medicaid Bulletin on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin/0705bulletin.pdf for more information.

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) **or** 90465 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPT code 90472 **or** 90466 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 **or** 90465 and 90466. 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.

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. When billing for immunizations with a Core visit use the provider's Medicaid number with the "A" suffix.**

- Administration of one immunization is billed with the CPT code 90471 (one unit) **or** 90465 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPT code 90472 **or** 90466 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.

Immunizations, continued

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 **or** 90465 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) **or** 90465 (one unit) with the **EP** modifier and is reimbursed at $27.42.

The immunization administration code is reimbursed at $27.42 regardless of the number of immunizations given. Immunization procedure codes must be reported even if the immunization administration fee is not being billed.

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 **or** 90465 with the EP modifier in block 24D at rate of $13.71. For additional immunizations, bill 90472 **or** 90466 with the EP modifier in block 24D at rate of $13.71. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one immunization, bill 90471 **or** 90465 with the EP modifier in block 24D at rate of $13.71. For additional immunizations, bill 90472 **or** 90466 with the EP modifier in block 24D at rate of $13.71. One immunization diagnosis code is required. Immunization procedure code(s) are required.	For one immunization, bill 90471**or** 90466 with the EP modifier in block 24D at rate of $13.71. For additional immunizations, bill 90472 **or** 90466 with the EP modifier in block 24D at rate of $13.71. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	N/A
FQHC/RHC	For one immunization, bill 90471 **or** 90465 with the EP modifier in block 24D at rate of $13.71. For additional immunizations, bill 90472 **or** 90466 with the EP modifier in block 24D at rate of $13.71. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one immunization, bill 90471 **or** 90465 with the EP modifier in block 24D at rate of $13.71. For additional immunizations, bill 90472 **or** 90466 with the EP modifier in block 24D at rate of $13.71. One immunization diagnosis code is required. Immunization procedure code(s) are required.	N/A	Cannot bill 90471 or 90472 **or** 90465 or 90466. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.
Local Health Department Providers	Cannot bill 90471 **or** 90465 . Must report immunizations. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one or more immunizations, bill 90471 **or** 90465 with the EP modifier at a rate of $27.42. One immunization diagnosis code is required. Immunization procedure code(s) are required.	For one or more immunizations, bill 90471 **or** 90465 with the EP modifier at a rate of $27.42. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.	N/A

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. The only 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
90633	Hepatitis A Vaccine (12 months through 18 years)	V05.3
90647	Hib PRP-OMP	V03.81
90648	Hib-4 dose PRP-T (ActHib)	V03.81
90655	Influenza , preservative free (6 through 35 months of age)	V04.81
90656	Influenza, preservative free (3 years and older) **Refer to ACIP Guidelines for children over 5 years**	V04.81
90657	Influenza (6 to 35 months of age)	V04.81
90658	Influenza (3 years of age and older) **Refer to ACIP Guidelines for children over 5 years**	V04.81
90669	Pneumococcal - PCV7 (2 through 59 months of age) **High-Risk Only for 24 through 59 months**	V03.82
90700	DTaP	V06.1
90702	DT	V06.5
90707	MMR	V06.4
90713	IPV	V04.0
90714	Td (7 through 18 years of age)	V06.5
90715	Tdap (7 through 18 years of age)	V06.1
90716	Varicella	V05.4
90718	Td (7 years of age and older)	V06.5
90723	Combination DTaP, IPV, and Hepatitis B (≥ 2 months through 6 years of age)	V06.8
90732	Pneumococcal - PPV23	V03.82
90734	Meningococcal (11 through 18 years of age) **Must be eligible for VFC and be in ACIP recommended coverage group**	V01.84
90744	Hepatitis B Vaccine – Pediatric/Adolescent If the first dose of Hepatitis B vaccine is administered prior to age 19, UCVDP vaccine can be used to complete the series prior to age 20.	V05.3

Universal Childhood Vaccine Distribution Program/Vaccines for Children Program, continued

A complete list of UCVDP/VFC vaccines is available at www.immunizenc.com. Providers interested in the coverage criteria can click on "Providers" and select UCVDP coverage criteria.

Note: Twinrix (Hep A/B combination) is available at certain ages and under certain criteria through the VFC program. For more information you may contact the Immunization Branch at 919-707-5550 or the Immunization Branch website at http://www.immunizenc.com .

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

PRIOR APPROVAL (PA) AND REQUESTING NON-COVERED SERVICES

Prior Approval

Certain services require Prior Approval (PA). If a service that requires **PA** is determined to be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition during a Health Check examination or other office visit, providers must first obtain PA before providing that service. Services that require PA and instructions for obtaining PA can be found at http://www.dhhs.state.nc.us/dma/bulletin/Section6.pdf. If the service requested is denied, reduced, or terminated the child's parent or legal representative may appeal the decision on behalf of the child. A letter of decision along with instructions on how to appeal the decision will be mailed to the child's parent or legal representative. Only recipients and guardians can request an appeal.

Requesting Non-Covered Services

If during a Health Check visit or other office visit a **non-covered service** is determined to be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening, providers must complete a **Non-Covered Services Request form or provide a letter of medical necessity that includes the information on this form**. The form along with instructions may be found at http://www.dhhs.state.nc.us/dma/Forms/NonCoveredServicesRequest.pdf. Mail or fax the Non-Covered Services Request form or letter of Medical Necessity to:

Assistant Director of Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

FAX: 919-715-7679

If the service requested is denied, reduced or terminated the parent or legal representative may appeal the decision on behalf of the child. A letter of decision along with instructions on how to appeal the decision will be mailed to the child's parent or legal representative. Only recipients and guardians can request an appeal.

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 tables on page 18.

- 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. All providers may refer to sample claims in this guide.

- 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. All providers may refer to sample claims in this guide.

- 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. All providers may refer to sample claims in this guide.

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.**

HEALTH CHECK BILLING REQUIREMENTS, continued

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.

All electronically submitted claims should list referral code indicator "E" in block 24H of the CMS 1500 claim form when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check examination. List referral code indicator "F" when a referral is made for Family Planning services.

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 of the CMS-1500 claim form when this situation occurs. All providers may refer to sample claims in this guide.

Requirement 5: Next Screening Date

Providers billing on paper may enter the next examination (screening) 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 examination (screening) date (NSD) for health check screening claims.

Health Check Billing Requirements, continued

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

All providers should refer to Billing Guidelines for Immunizations chart in this guide regarding billing immunization administration CPT codes and the EP modifier. All providers may refer to sample claims in this guide.

When billing one immunization, private providers must use the administration CPT code 90471 or 90465 (one unit) with the EP modifier listed in block 24D.

When additional immunizations are provided, private providers must use the administration CPT code 90472 or 90466 with the EP modifier listed in block 24D.

Note: If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90471 and 90472 **or** 90465 and 90466 is $0.00.

ICD-9 AND CPT CODES

The following table lists ICD-9 and CPT codes related to Health Check examinations:

	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, 12, 18 or 24 months of age, at age 3, 4, and 5 years of age 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

PREVENTIVE MEDICINE CPT CODES

The following table lists Preventive Medicine CPT codes that must be listed on the CMS 1500 when filing a claim for a Periodic (V20.2) or an Interperiodic (V70.3) examination. The **EP modifier** must be listed in block 24D of the CMS 1500 with the appropriate Preventive Medicine code.

Age	New Patient	Established Patient	Append EP modifier
Under age 1 year	99381	99391	Yes
1 through 4 years	99382	99392	Yes
5 through 11 years	99383	99393	Yes
12 through 17 years	99384	99394	Yes
18 through 20 years	99385	99395	Yes

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, 12, 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.

- Report payments received from third party insurance 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 **or** 90465 with the EP modifier and 90472 **or** 90466 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 examination 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 **or** 90465 with the EP modifier and 90472 **or** 90466 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 90471 **or** 90465 with the EP modifier and 90472 **or** 90466 with the EP modifier. Refer to sample claims in this guide.

- 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 (FQHC) and Rural Health Clinic (RHC) Providers Only

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

- When billing for immunizations with a core visit use the provider's Medicaid number with the "A" 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 **or** 90465 with the EP modifier and 90472 **or** 90466 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 an examination code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 **or** 90465 with the EP modifier and 90472 **or** 90466 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 **or** 90465 with the EP modifier and 90742 **or** 90466 with the EP modifier. Refer to sample claims in this guide.

Local Health Departments

- 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 90471 **or** 90465, the EP modifier must be entered in data field on the HSIS Services Screen to receive the reimbursement rate of $27.42. If the EP modifier is not entered the reimbursement will be $0.00 per unit. The reimbursement for these codes is $3.41 per unit for non-Health Check related services. There is no additional reimbursement for CPT immunization administration codes 90472 or 90466.

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.

HCCs currently provide assistance to 91 North Carolina counties and the 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/ca/hcc.pdf.

The roles of the HCC includes 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
- Educating families about the importance of establishing a medical home for their children
- 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 Health Check or follow-up examinations
- Promoting Health Check and health prevention with other public and private organizations

Physicians, primary care providers (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.

Denial – Explanation of Benefits (EOB)

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 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 examination according to the billing guidelines. Correct claim and resubmit.
301	Physician visit not allowed same day as Health Check by same provider or member of same group.	Resubmit as an adjustment with documentation supporting related services.
349	Health Check Screen and related service not allowed same day, same provider, or member of same group.	Resubmit as an adjustment with documentation supporting unrelated services.
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 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 examination. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic examination with primary diagnosis V20.2 and interperiodic examinations with primary diagnosis V70.3. Check the preventive medicine code entered in block 24D of the claim form and append the EP modifier.
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 hearing and/or vision service.	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 primary 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 V25.9.
1771	All components were not rendered for this Health Check examination.	For periodic 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 BILLING WORKSHEET

Date of Service ____________________

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

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

Health Check Examination 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 Screening based on age	Vision Screening CPT Code 99172 or 99173 With EP Modifier		
Hearing Screening based on age	Hearing Screening 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 HC provider or another provider	R; providers billing on paper E or F; providers billing electronically	
Third Diagnosis _________________ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	R; providers billing on paper E or F; providers billing electronically	
Fourth Diagnosis _________________ (if applicable)		
Description	**Indicator**	✓
Follow-up with HC provider or another provider	R; providers billing on paper E or F; providers billing electronically	

Description	**CPT Codes**	**Unit**	
Immunization Administration Fee	90471 **or** 90465 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 **or** 90466 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	V05.3	VFC 12 mo – 18 yrs
90647	Hib PRP-OMP	V03.81	VFC 2 mo- 18 yrs
90648	Hib – 4 dose (Brand name – ActHib)	V03.81	
90655	Influenza, split virus, preservative free (6-35 months of age)	V04.81	VFC 6 mo – 35 mo
90656	Influenza – Age 3 & up	V04.81	VFC 3 yrs – 18 yrs
90657	Influenza, split virus (6 to 35 months of age)	V04.81	VFC 6 mo – 35 mo
90658	Influenza, split virus (Age 3 and up)	V04.81	VFC 3 yrs – 18 yrs
90669	Pneumococcal PCV7 (2-59 months)	V03.82	VFC 2 mo – 5 yrs
90675	Rabies Vaccine – IM	V04.5	
90700	DTaP	V06.1	VFC 2 mo – 7 yrs
90702	DT – Age under 7	V06.5	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
90714	Td	V06.5	
90715	Tdap	V06.1	VFC 11 yrs – 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	Hep B, DTaP, and IPV	V06.8	VFC 2 mo – 6 yrs
90732	Pneumococcal PPV23	V03.82	VFC 2 yrs – 18 yrs
90734	Meningococcal MCV4	V01.84	VFC 11 yrs – 18 yrs
90733	Meningococcal	V03.89	
90744	Hepatitis B Vaccine – Pediatric/adol -3 dose	V05.3	VFC 0 – 19 yrs
90746	Hepatitis B Vaccine – Age 20 and above	V05.3	
90747	Hepatitis B Vaccine - Dialysis Pt./immunosuppressed - 4 dose	V05.3	

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/.

Resource List

North Carolina Medicaid Special Bulletin, December 2005, Medicaid for Children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Health Check
http://www.dhhs.state.nc.us/dma/bulletin/EPSDT.pdf

Policy Instructions: Early and Periodic Screening, Diagnostic and Treatment
http://www.dhhs.state.nc.us/dma/epsdt_policy.pdf

Recommendations for Preventive Pediatric Health Care
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/3/645

Prior Approval Process and Request for Non-Covered Services
DMA Special Bulletin, January 2006
http://www.dhhs.state.nc.us/dma/bulletin/0105bulletin.pdf

Developmental Screening standardized and validated screening tools
www.dbpeds.org/.

Developmental Surveillence and Screening
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/192.

Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2006.
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5451-Immunization a1.htm

Dental Varnishing
General Medicaid Bulletin, August 2002
http://www.dhhs.state.nc.us/dma/bulletin/0802bulletin1.htm

North Carolina Lead Screening and Follow Up Manual
http://www.deh.enr.state.nc.us/ehs/Children_Health/printedversionleadmanual.pdf.

Universal Vaccine for Children Distribution Program
www.immunizenc.com

North Carolina Immunization Branch
www.immunizenc.com

National HIPAA Implementation Guide
http://www/wpc-edi.com.

North Carolina 837 Professional Claim Transaction Guide
http://www.dhhs.state.nc.us/dma/hipaa/837prof.pdf

Health Check Coordinator Contact List
http://www.dhhs.state.nc.us/dma/ca/hcc.pdf

Resource List, continued

NC Healthy Start Foundation
http://www.nchealthystart.org/.

NC Family Health Resource Line
1-800-367-2229

Children with Special Health Care Needs Helpline
1-800-737-3028

EDS
1-800-688-6696

FEDERAL MEDICAID COVERED SERVICES--42 U.S.C. § 1396d(a)

Inpatient hospital services (other than services in an institution for mental disease)
Outpatient hospital services
Rural health clinic services (including home visits for homebound individuals)
Federally-qualified health center services
Other laboratory and X-ray services (in an office or similar facility)
EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered*
services necessary to correct or ameliorate a *diagnosed physical* or mental condition)
Family planning services and supplies
Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)
Medical and surgical services furnished by a dentist
Home health care services, including nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services
Private duty nursing services (in the home, hospital, and/or skilled nursing facility)
Clinic services (including services outside of clinic for eligible homeless individuals)
Dental services
Physical therapy and related services (includes occupational therapy and services for individuals with speech, hearing, and language disorders)
Prescribed drugs
Dentures
Prosthetic devices
Eyeglasses
Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)
Services in an intermediate care facility for the mentally retarded
Inpatient psychiatric hospital services for individuals under age 21
Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle
Hospice care
Case-management services
TB-related services
Respiratory care services
Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
Primary care case management services
Any other medical care, and any other type of remedial care recognized under state law, specified by the
secretary (includes transportation)

01/28/05

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

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O.Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

PLEASE DO NOT STAPLE IN THIS AREA

Private Provider
Periodic Examination
Developmental Screening

PICA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE / MEDICAID [X] / 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, Joe

3. PATIENT'S BIRTH DATE: 01 31 04 — SEX: M [X]

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

CITY: Raleigh — STATE: NC

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. V20 . 2

24A Date(s) of Service From (MM DD YY)	To (MM DD YY)	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
03 03 06	03 03 06	11		99382	EP		80 33	1				
03 03 06	03 03 06	11		96110	EP		0 00	1				

28. TOTAL CHARGE: $ 80 33
29. AMOUNT PAID: $
30. BALANCE DUE: $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER: Signature on File — DATE: 03/23/06

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:
Dr. Jane Recipient
111 Provider Street
Provider Town, NC 12345
PIN# 9999999 GRP# 0000001

PLEASE DO NOT STAPLE IN THIS AREA

Private Provider
Immunizations Only

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY: 09 06 01 SEX M [X] F

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

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

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

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

CITY: Raleigh STATE: NC

8. PATIENT STATUS: Single / Married / Other

CITY / STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 555-1212

Employed / Full-Time Student / Part-Time Student

ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V06 1
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
03	21	06	03	21	06	11		90471	EP		13 71	1				
03	21	06	03	21	06	11		90472	EP		13 71					
03	21	06	03	21	06	11		90700	EP		0 00	1				
03	21	06	03	21	06	11		90713	EP		0 00	1				
03	21	06	03	21	06	11		90707	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 $ 27 42

29. AMOUNT PAID $

30. BALANCE DUE $ 27 42

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 03/23/06
SIGNED DATE

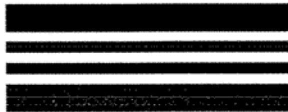
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

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

PIN# 9999999 GRP# 0000001

PLEASE DO NOT STAPLE IN THIS AREA



Private Provider
Interperiodic Screening
Referral Indicator "F"

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY: 02 27 91 SEX M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Raleigh STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 555-1212

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

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

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

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

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 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
02 28 06	02 28 06	11		99394	EP		80 33	1	F			

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 03/20/06
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 #

Community Healthcare
Health Start Rd.
Raleigh, NC 27600

PIN# 8888888 GRP# 7777777

PLEASE DO NOT STAPLE IN THIS AREA

Private Provider
Interperiodic Screening
Immunizations

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX
11 20 94 M F [X]

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

5. PATIENT'S ADDRESS (No., Street)
111 Carolina Lane

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

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

CITY STATE
Raleigh NC

8. PATIENT STATUS
Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)
12345 (919) 555-1212

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE)
( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 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
01	05	06	01	05	06	11		99383	EP		80 33	1				
01	05	06	01	05	06	11		90471	EP		13 71	1				
01	05	06	01	05	06	11		90472	EP		13 71	1				
01	05	06	01	05	06	11		90715	EP		0 00	1				
01	05	06	01	05	06	11		90716	EP		0 00	1				
01	05	06	01	05	06	11		90707	EP		0 00					

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 03/20/06
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 #

Community Healthcare
Health Start Rd.
Raleigh, NC 27600

PIN# 8888888 GRP# 7777777

PLEASE DO NOT STAPLE IN THIS AREA

Private Provider- SPLIT CLAIM
Periodic Examination
Developmental, Vision and Hearing Screenings
Referral Indicator "R"; Immunizations(NEXT PAGE)

HEALTH INSURANCE CLAIM FORM

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

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

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

3. PATIENT'S BIRTH DATE (MM DD YY): 03 02 02 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: Raleigh 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) 555-1212

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20 2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

From MM	From DD	From YY	To MM	To DD	To YY	B Place of Service	C Type of Service	D CPT/HCPCS	D Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
03	03	06	03	03	1	11		99382	EP		80 33	1	R			
03	03	06	03	03	06	11		96110	EP		0 00	1				
03	03	06	03	03	06	11		99172	EP		0 00	1				
03	03	06	03	03	06	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 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 03/20/06

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. Joe Love
333 Lovers Lane
Love, NC 12345

PIN# 8888888 GRP# 0000001

PLEASE DO NOT STAPLE IN THIS AREA

2nd page of split claim
Continued from previous page
Private Provider
Immunizations

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

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

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

3. PATIENT'S BIRTH DATE (MM DD YY): 03 02 02 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: Raleigh 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) 555-1212

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V03 82
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

From MM	From DD	From YY	To MM	To DD	To YY	B Place of Service	C Type of Service	D CPT/HCPCS	D Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
03	03	06	03	03	1	11		90465	EP		13 71	1				
03	03	06	03	03	06	11		90466	EP		13 71	1				
03	03	06	03	03	06	11		90732	EP		0 00	1				
03	03	06	03	03	06	11		90700	EP		0 00	1				
03	03	06	03	03	06	11		90707	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: $ 27 42

29. AMOUNT PAID: $

30. BALANCE DUE: $ 27 42

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 03/20/06
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. Joe Love
333 Lovers Lane
Love, NC 12345

PIN# 8888888 GRP# 0000001

PLEASE DO NOT STAPLE IN THIS AREA

Private Provider
Periodic Examination
Vision and Hearing Screenings
Referral Indicator "E"

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

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

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

3. PATIENT'S BIRTH DATE (MM DD YY): 03 01 97 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: Raleigh 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) 555-1212

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

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

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

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 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
03	03	06	03	03	1	11		99383	EP		80 33	1	E			
03	03	06	03	03	06	11		99172	EP		0 00	1				
03	03	06	03	03	06	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 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 03/20/06
SIGNED DATE

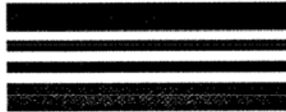
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

Dr. Joe Love
333 Lovers Lane
Love, NC 12345

PIN# 8888888 GRP# 0000001

PLEASE DO NOT STAPLE IN THIS AREA



FQHC/RHC
Periodic Examination
Vision and Hearing Screenings

PICA **HEALTH INSURANCE CLAIM FORM** PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 04 93 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: Raleigh 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 CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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
04 16 06	04 16 1	11		99394	EP		80 33	1				
04 16 06	04 16 06	11		99172	EP		0 00	1				
04 16 06	04 16 06	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 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 04/20/06
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. Joe Love
333 Lovers Lane
Love, NC 12345

PIN# 0000000 GRP# 100000C

PLEASE DO NOT STAPLE IN THIS AREA

FQHC/RHC
Interperiodic Examination
Referral Indicator "F"

HEALTH INSURANCE CLAIM FORM

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER: X (Medicaid #)

1a. INSURED'S I.D. NUMBER: 111111111X

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

3. PATIENT'S BIRTH DATE: 07 25 87 — SEX: 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: Raleigh — STATE: NC

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

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

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

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO
b. AUTO ACCIDENT? YES / NO — PLACE (State)
c. OTHER ACCIDENT? YES / NO

10d. RESERVED FOR LOCAL USE

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-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

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

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM / TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM / TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 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 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
04 19 06	04 19 06	11		99395	EP		80 33	1	F			

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 — 04/26/06
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. Joe Love
333 Lovers Lane
Love, NC 12345

PIN# 0000000 — GRP# 100000C

PLEASE DO NOT STAPLE IN THIS AREA

FQHC/RHC
Immunizations Only

HEALTH INSURANCE CLAIM FORM

1. MEDICAID: X (Medicaid #)
1a. INSURED'S I.D. NUMBER: 111111111X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe
3. PATIENT'S BIRTH DATE: 12 20 04 SEX: M X
5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street
CITY: Raleigh STATE: NC
ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. V03 81

From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	CPT/HCPCS	Modifier	Diagnosis Code	$ Charges	Days or Units
04	28	06	04	28	06	11		90471	EP		13 71	1
04	28	06	04	28	06	11		90472	EP		13 71	1
04	28	06	04	28	06	11		90713	EP		0 00	1
04	28	06	04	28	06	11		90716	EP		0 00	1
04	28	06	04	28	06	11		90647	EP		0 00	1
04	28	06	04	28	06	11		90700	EP		0 00	1

28. TOTAL CHARGE: $ 27 42
29. AMOUNT PAID: $
30. BALANCE DUE: $ 27 42

31. SIGNATURE OF PHYSICIAN OR SUPPLIER: Signature on File DATE: 04/28/06

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:
Dr. Joe Love
333 Lovers Lane
Love, NC 12345
PIN# 0000000 GRP# 100000C

PLEASE DO NOT STAPLE IN THIS AREA

FQHC/RHC
Core Visit
Immunizations

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

3. PATIENT'S BIRTH DATE (MM DD YY): 11 21 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: Raleigh — 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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 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
03	28	06	03	28	06	11		T1015	EP		65 00	1				
03	28	06	03	28	06	11		90700	EP		0 00	1				
03	28	06	03	28	06	11		90707	EP		0 00	1				
03	28	06	03	28	06	11		90716	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: $ 65 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 65 00

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 — 03/28/06

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. Joe Love
333 Lovers Lane
Love, NC 12345

PIN# 0000000 — GRP# 100000A

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 Screening 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 Screening 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 Screening 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 Screening 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
```

Mark T. Benton, Sr
Senior Deputy Director and Chief Operating Officer
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