North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

Visit our website at www.dhhs.state.nc.us/dma.

Number IV **May 2005**

Attention:

Mental Health Providers who are employed in Physician Offices/Clinics, Hospital Outpatient Departments, LME, and Local Health Departments/School Based Health Centers

Expansion of Provider Types for Outpatient Behavioral Health Services Phase II

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Outpatient Behavioral Health Services Provided by Direct Enrolled Providers

Mental Health Practitioners who are employees of Physician's Offices/Clinics, Hospital Outpatient Departments, Local Health Departments and Local Management Entities:

On February 1, 2005 Medicaid expanded the list of clinicians who could direct enroll and provide Medicaid reimbursable services to children and adults. This was implemented as the first phase of mental health reform.

Phase II implementation will be effective with date of service July 1, 2005. This phase will focus on providers of outpatient mental health therapy/counseling services, who are employed in physician offices/clinics, hospital outpatient departments, local health departments/school-based health centers and area program/local management entities to include the provider types listed below. Each provider listed must direct enroll with Medicaid to be eligible to provide outpatient mental health services to adults and children.

Eligible Providers

The following is a list of providers required to enroll:

- Licensed Psychologists (doctorate level)
- Licensed Psychological Associates (LPA)
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Clinical Social Workers (LCSW)
- Nurse Practitioners, Certified as an Advanced Practice Psychiatric Nurse Practitioner*****
- Certified Clinical Nurse Specialist in Psychiatric Mental Health Advance Practice
- Certified Clinical Supervisors (CCS)
- Certified Clinical Addictions Specialists (CCAS)

***Note:** The Division of Medical Assistance will allow nurse practitioners who possess an Advanced Certification in areas other than psychiatric nursing, and who have two years of mental health experience to enroll under a sunset clause. Under this clause all Nurse Practitioners will be required to complete and submit the Advanced Psychiatric Certification on or before June 30, 2010 to Provider Enrollment at DMA. Failure to complete the certification by June 30, 2010 will result in termination of participation in the Medicaid program.

The provider types listed above may also provide services "incident to" a physician if they are employed in a physician's office or a physician directed clinic. A physician directed clinic is described as a clinic that is run under the supervision of a physician and staff are employed by the physician or staff and physician are employed by the same legal entity. However, all mental health practitioner services being billed under "incident to" must meet the following guidelines:

- The services being rendered are the kind that are commonly furnished in a physician's office or clinic.
- Direct physician supervision is defined as follows:

1) The physician has initially seen the patient.
2) The physician should be present in the office suite in which the practitioner is providing the service and immediately available in the event of an emergency.
3) The physician must be able to provide evidence of management of the patient's care.

- The practitioner must only provide services that fall under the scope of practice for the applicable licensure

Beginning July 1, 2005, all services must be billed with the practitioner's individual provider number listed in block 33 on the CMS-1500 claim form; payment will be made at the discipline rate, unless services are provided "incident to" and meet the above guidelines. **If you are providing services "incident to", your individual number should not appear on the claim**. The supervising physician's provider number should be listed in block 33 on the CMS-1500 claim form if an independent practitioner's services are being billed "incident to" physician services.

Eligible Recipients

Medicaid eligible recipients may have service restrictions due to their eligibility category that would make them ineligible for Mental Health services. Providers should refer to Basic Medicaid Guidelines currently listed on the DMA web site as Basic Medicaid Billing Guide 2005 **http://www.dhhs.state.nc.us/dma/medbillcaguide.htm** or the mental health clinical coverage policies currently listed on the DMA we site at **http://www.dhhs.state.nc.us/dma/mp/mpindex.htm** for detailed information on recipient coverage limitations.

Requirements for and Limitations on Coverage

Medicaid payment for covered services is limited to those services rendered by the qualified providers enrolled in the Medicaid Program. Services must be medically necessary, individualized, specific, consistent with symptoms or with a confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.

Service Limitations

1. Medicaid does not reimburse for the same services provided by the same provider for the same date of service.
2. Only one (1) psychiatric interview (CPT codes 90801 and 90802) by the same provider is allowed in a six month period.
3. Prior approval and order for the service is required after 8 visits for adults (21 and older) and after 26 visits for children (under age 21).

Referral Requirements

Recipients under the age of 21

Practitioners who are providing services in a local health department, a school based health center or a hospital outpatient department, must obtain a referral prior to a recipient's first visit. The referral must come from the recipient's Carolina Access (CA) primary care physician (PCP), the LME or a Medicaid enrolled psychiatrist.

Practitioners who are employed and working for a CA Primary Care Physician or Medicaid enrolled psychiatrist billing under the "incident to" guidelines will not need a referral. However, if the practitioner is working independently, if the recipient is a child, and the physician is not a psychiatrist or a CA PCP, a referral will still have to be obtained per guidelines above. Claims must be billed as a multispecialty group, not as a

physician claim.Referral may be made by telephone, fax or in writing to the mental health provider. The referring number must be listed in block 19 of the CMS-1500 claim form. Failure to put the referral number on the claim when filing will result in denial of payment.

Recipients over the age of 21

Adults do not require a referral authorization prior to the first visit.

Prior Approval Requirements

Recipients under the age of 21

Coverage is limited to 26 visits each calendar year for recipients under 21 without prior approval.

Between the 20th and 26th visits a written request for prior approval should be submitted to ValueOptions or the Piedmont Cardinal Health Plan if the recipient is a resident of Cabarrus, Rowan, Stanley, Union or Davidson counties for review and authorization. If the recipient is receiving multiple services from more than one provider, the providers must coordinate care to determine the number of unmanaged visits that have been utilized.

Reminder: If the recipient turns 21 within the calendar year, the unmanaged visit limit decrease to eight visits as indicated above.

A copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant should accompany the request for prior approval. CPT code 90862 medication management is not subject to prior approval nor is it counted in the number of unmanaged visits.

Recipients age 21 and over

Coverage is limited to 8 visits each calendar year for recipients 21 and over without prior approval. Between the 4th and 7th visits a written request for prior approval should be submitted to ValueOptions or the Piedmont Cardinal Health Plan if the recipient is a resident of Union, Cabarrus, Stanley, Rowan or Davidson counties for review and authorization.

Procedure codes denoting group treatment services (90846, 90847, 90849, 90853, 90857, H0005 and H0004 with the appropriate modifier HR, HS, or HQ) are counted during the unmanaged visits period as one half visit and not one whole visit. Therefore, during the eight unmanaged visit period providers may have a combination of group visits and individual visits. For example, four individual visits and eight group visits. This total count equals eight. Another option is all group visits; in which is the case you would request prior approval after 16 group visits.

If the recipient is receiving multiple services from more than one provider, the providers need to coordinate care to determine if the number of unmanaged visits have been utilized. A copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 8th visit.

CPT code 90862 is not counted in the unmanaged visits and is, therefore, not subject to prior approval. However it is counted in the 24-visit limit for ambulatory medical services.

Place of Service

Recipients under the age of 21

Services may be provided in the office/clinic, hospital outpatient department, area program/LME, school, home, or residential facilities.

Recipients age 21 and over

Services may be provided in the office/clinic, hospital outpatient department, area program/LME, home, adult care home, assisted living or nursing facility.

Consent

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

Coordination of Care

Coordination of care activities are not a Medicaid billable service. The behavioral health practitioners are responsible for the coordination of care activities with the referral source or the recipient's physician which may include but are not limited to the following:

1. Written progress or summary reports
2. Telephone communication
3. Treatment planning process
4. Other activities jointly determined by the referring provider and the behavioral health provider to be necessary for the continuity of care

Documentation Requirements

The North Carolina Medicaid program requires providers to maintain records for each Medicaid recipient documenting the provision of services for a minimum of 5 years.

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

All Recipients

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

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

9. Additional requirements may apply to each particular service

Recipients under the age of 21

Documentation must also include:

1. Before the initial visit, a referral from a CA PCP, Medicaid-enrolled psychiatrist or LME.
2. Copy of the written order for continuing care from the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 26th visit.
3. Copy of the completed authorization form and prior approval notification from the utilization review contractor after the 26th visit.
4. Behavioral Health services provided by a Medicaid enrolled physician, physician assistant, nurse practitioner, or licensed psychologist (doctorate level) do not require an order.

Recipients age 21 and over

Documentation must also include:

1. Copy of the written order by the medical doctor, licensed psychologist (doctorate level), nurse practitioner or physician assistant after the 8th visit.
2. Copy of the completed authorization form and prior approval notification from the utilization review contractor after the 8th visit.
3. Services provided by a Medicaid enrolled physician, physician assistant, nurse practitioner, or licensed psychologist (doctorate level) do not require an order.

Note: 1. Services provided by an LME do not require a referral
2. Services provided by a Medicaid enrolled physician do not require an order
3. Written orders and prior approval do not need to be submitted with the CMS-1500 claim form
4. Provisional and non-licensed staff will be allowed to bill through the LME until six months after implementation of the new and enhanced benefit package.

Billing Guidelines

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

Claim Type

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

Diagnosis Codes that Support Medical Necessity

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

Diagnosis Codes Requirements for Recipients under the age of 21

Medicaid covers six unmanaged visits without a diagnosis of mental illness.
The first two visits can be coded with ICD-9-CM code 799.9 (a nonspecific code)
The following four visits may be coded with a diagnosis code of V01.0 through V82.9.
Or
The first visit may be coded with diagnosis 799.9
The remaining five can be coded with V01.0 through V82.9

A specific diagnosis code should be used as soon as a diagnosis is established.
Visits seven and beyond require an ICD-9-CM code between 290 through 319.
The ranges of V codes to be used are diagnosis codes V01.0 through V82.9.

Procedure Codes

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

Mental health specific codes are billable by physicians according to the services they render and are subject to prior approval.

Other practitioners bill specific codes as indicated below and payment is made according to the specialty of the practitioner delivering the service, whether practicing independently or employed by a physician or a clinic.

Procedure Codes

Professional Specialty	Related Codes
Licensed Psychologist	96100, 96110, 96111, 96115, 96117, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Licensed Psychological Associate	96100, 96110, 96111, 96115, 96117, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS
Licensed Professional Counselor	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Licensed Marriage And Family Therapist	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Licensed Clinical Social Worker	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0004, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)
Psychiatric Nurse Practitioner (Certified)	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90862, 90805, 90807, 90811, 90813, 90815 90816, 90818, 90821, 90823, 90826, 90828 in residential facilities H0031, H0001, H0005 H0004 (with / without an appropriate modifier – HQ, HR, or HS)

Procedure Codes continued

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

CMS-1500 Claim Form Instructions

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

Block	Block Name	Explanation
1.	**Type of Coverage**	Place an (X) in the Medicaid block**.**
1a.	**Insured's ID Number**	Enter the recipient's ten-character identification number found on the MID card.
2.	**Patient's Name**	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	**Patient's Birth Date**	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
	Sex	Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).
5.	**Patient's Address**	Enter the recipient's street address including city, state, and zip code.
	Telephone	Entering the recipient's telephone number is optional.
9.	**Other Insured's Name**	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
15.	**If Patient Has Had Same or Similar Illness, Give First Date**	Leave blank **Note:** A two-digit year is acceptable on paper claims. A four-digit year is **required** for electronic claims.
19.	**Reserved for Local Use**	**Recipients under the age of 21:** Enter the referral by a Carolina ACCESS primary care provider (PCP), the local management entity (LME) or a Medicaid enrolled psychiatrist. **Recipients age 21 and over:** Services provided to recipients age 21 and over may be self referred or referred by any source.

CMS-1500 Claim Form Instructions continued

Block	Block Name	Explanation
21.	**Diagnosis or Nature of Illness or Injury**	Provider must bill the ICD-9 diagnosis code to the highest level of specificity that supports medical necessity. Diagnosis code requirements for recipients under the age of 21: The first two visits can be coded with ICD-9-CM code 799.9 The following four visits can be coded with a diagnosis code of V01.0 through V82.9 **Or** The first visit can be coded with diagnosis 799.9 The remaining five can be coded with V01.0 through V82.9 A specific diagnosis code should be used as soon as a diagnosis is established. Visits seven and beyond require ICD-9-CM code between 290-319.
23.	**Prior Authorization Number**	It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file. Prior approval and written orders do not need to be submitted with the CMS-1500 claim form.
24A.	**Date(s) of Service "From" and "To"**	Enter the eight-digit date of service in the "From" block. Example: Record the date of service January 31, 2005 as 01312005. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block. **Note:** A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.
24B.	**Place of Service**	**Recipients under 21:** Place of service is limited to office/clinic, hospital outpatient department, area program/LME, school or home, or residential facility. **Recipients age 21 and over:** Place of service is limited to office/clinic, hospital outpatient department, area program/LME, home, adult care home, assisted living or nursing facility.
24C.	**Type of Service**	Effective date of processing October 16, 2003, Type of Service is no longer required.
24D.	**Procedures, Services, or Supplies**	Enter the appropriate five-digit CPT or HCPCS code.
24F.	**Charges**	Enter the usual and customary charge for each service rendered.
24G.	**Days or Units**	Enter the number of visits or units.

Claim Form Instructions, continued

Block	Block Name	Explanation
26.	**Patient's Account No.**	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by the fiscal agent and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
28.	**Total Charge**	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient was private pay or had Third Party coverage.)
29.	**Amount Paid**	Total amount paid by another payor other than Medicaid. Do not enter a Medicaid payment in this block.
31.	**Signature of Physician or Supplier Including Degrees or Credentials**	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a **Provider Certification for Signature on File form** has been completed and submitted to the fiscal agent, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
33.	**Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.**	Enter the billing provider's name, street address including zip code, and phone number. **PIN #:** Enter the attending physician's seven-character Medicaid provider number. Incident to: The supervising physician's provider number entered in the attending field. **GRP #:** Enter the seven-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).

Place of Service Code Index

POS Code	Description	Explanation
03	**School**	A facility whose primary purpose is education.
11	**Office/Clinic/LME**	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	**Home**	Home is considered the recipient's private residence, which also includes an adult care home facility.
22	**Outpatient Hospital**	A section of a hospital that provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
32	**Nursing Facility**	A facility that primarily provides skilled and intermediate nursing care to residents and provides related services for the rehabilitation of injured, disabled or sick persons or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	**Custodial Care Facility**	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component.
53	**Community Mental Health Center**	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	**Intermediate Care Facility/Mentally Retarded**	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or nursing facility.
61	**Comprehensive Inpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.

Place of Service Code Index continued

POS Code	Description	Explanation
62	**Comprehensive Outpatient Rehabilitation Facility**	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
99	**Other Unlisted Facility**	Other unlisted facilities not identified above, such as a school.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Age – 4
Place of Service – Office
No Prior Approval- under 26 unmanaged
Group number required

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

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

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

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

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

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

CITY: Recipient Town — STATE: NC

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

CITY — STATE

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (555) 555-5555

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

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

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

b. AUTO ACCIDENT? YES | NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE: 1234567

20. OUTSIDE LAB? YES | NO — $ CHARGES

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

1. 290 3. 2. 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 02 05	07 02 05	11		90802			140 88	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN | EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $ 140 88

29. AMOUNT PAID: $

30. BALANCE DUE: $ 140 88

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on file 07-01-2005

SIGNED — DATE

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

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

Dr. Jane Provider 123 Any Street Any Town, N.C. 12345

PIN# 2222222 GRP# 1111111

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Age – 5
Place of Service – Office
Prior Approval Required
Group number required

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☑ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe	3. PATIENT'S BIRTH DATE MM 01 DD 04 YY 00 SEX M ☑ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY: Recipient Town STATE: NC	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY STATE
ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 555-5555	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE: 1234567		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 311 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 05 05	07 05 05	11		96117			62 40	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 62 40
29. AMOUNT PAID $	30. BALANCE DUE $ 62 40		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on file 07-01-2005 SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Dr. Jane Provider 123 Any Street Any Town, N.C. 12345 PIN# 2222222 GRP# 1111111

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0 -0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Age – 34
Place of Service – Office
Self Referral
No Carolina Access
Group number required

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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

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

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

3. PATIENT'S BIRTH DATE: 01 01 71 SEX: M ☐ F ☑

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

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

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

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

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 555-5555

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

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

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

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

1. 310 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 06 05	07 06 05	11		90808			134 73	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 134 73

29. AMOUNT PAID $

30. BALANCE DUE $ 134 73

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on file 07-01-2005

SIGNED DATE

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

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

Dr. Jane Provider 123 Any Street Any Town, N.C. 12345

PIN# 2222222 GRP# 1111111

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)